

RECEIVED

MAR - 7 2008

UNITED STATES DISTRICT COURT
FOR THE
NORTHERN DISTRICT OF CALIFORNIA
RICHARD W. WIEKING
CLERK, U.S. DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

EDWARD GUTIERREZ,
PLAINTIFF,

V.

CASE NUMBER: CV07-04251 MMC
CERTIFICATE OF SERVICE
AMENDED COMPLAINT.

SANTA CLARA COUNTY,
DR. ALEXANDER CHYORNY,
et al,
DEFENDANT(S).

I, THE UNDERSIGNED, HEREBY CERTIFY THAT I AM
THE PLAINTIFF, IN THE SANTA CLARA COUNTY DEPARTMENT
OF CORRECTION, IN SAN JOSE CALIFORNIA.

THAT ON MARCH, . 2008, I SERVED A TRUE AND
CORRECT COPY (IES) OF THE ATTACHED, BY PLACING
SAID COPY(IES) IN A POSTAGE PAID ENVELOPE ADD-
RESSED TO THE PERSON(S) HEREINAFTER LISTED, BY
DEPOSITING SAID ENVELOPE IN THE U. S. MAIL, OR BY
PLACING SAID COPY(IES) INTO THE HANDS OF A
SANTA CLARA COUNTY D.O.C. LEGAL COORDINATOR.

CLERK, U. S. DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
450 GOLDEN GATE AVE.
SAN FRANCISCO, CA.
94102

SERVED ON:

SIGNATURE OF SERVED

DATE:

SERVED BY:

EDWARD GUTIERREZ PLAINTIFF.
06083610 / BGJ774
885 N. SAN PEDRO ST.
SAN JOSE, CA. 95110.

DATE:

1
2 DEAR CLERK, U.S. DISTRICT COURT,
3
4 WILL YOU PLEASE SIGN AND
5
6 RETURN, TO ME, THIS CERTIF-
7
8 ICATE OF SERVICE...

9 P.S. PROOF OF SERVICE NEEDED
10 TO CONTINUE LEGAL RESEARCH. THANK YOU!
11

12 DATE: 3- -2008



13
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15
16
17 EDWARD GUTIERREZ
18 06083690 - BGJ774
19 885 N. SAN PEDRO ST.
20 SAN JOSE, CA. 95110.

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27
28
CASE No. C07-4251 MMC (PR).

AMENDED COMPLAINT.

JS 44 - CAND (Rev. 11/04)

CIVIL COVER SHEET

The JS-44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. (SEE INSTRUCTIONS ON PAGE TWO.)

I.(a) PLAINTIFFS EDWARD GUTIERREZDEFENDANTS: DR. ALEXANDER CHYORNY, LORI HORN, R.N., DR. JOHN C. LUKRICH, DR. MARIA JUAREZ-REYES, DR. ANITA GADDIPATI, DR. G. VERSALES, C/O WARFIELD #2642, EDWARD C. FLORES, CAPTAIN D. SEPULVEDA.(b) COUNTY OF RESIDENCE OF FIRST LISTED PLAINTIFF SANTA CLARA
(EXCEPT IN U.S. PLAINTIFF CASES)COUNTY OF RESIDENCE OF FIRST LISTED DEFENDANT SANTA CLARA
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

(c) ATTORNEYS (FIRM NAME, ADDRESS, AND TELEPHONE NUMBER)

EDWARD GUTIERREZ, PLAINTIFF.

ATTORNEYS (IF KNOWN)

II. BASIS OF JURISDICTION (PLACE AN "X" IN ONE BOX ONLY)

- ☐ 1 U.S. Government Plaintiff
- ☒ 3 Federal Question (U.S. Government Not a Party)
- ☐ 2 U.S. Government Defendant
- ☐ 4 Diversity (Indicate Citizenship of Parties in Item III)

III. CITIZENSHIP OF PRINCIPAL PARTIES (PLACE AN "X" IN ONE BOX FOR PLAINTIFF AND ONE BOX FOR DEFENDANT)

- | | PTF | DEF | | PTF | DEF |
|---|---------------------------------------|---------------------------------------|---|----------------------------|----------------------------|
| Citizen of This State | <input checked="" type="checkbox"/> 1 | <input checked="" type="checkbox"/> 1 | Incorporated or Principal Place of Business in This State | <input type="checkbox"/> 4 | <input type="checkbox"/> 4 |
| Citizen of Another State | <input type="checkbox"/> 2 | <input type="checkbox"/> 2 | Incorporated and Principal Place of Business in Another State | <input type="checkbox"/> 5 | <input type="checkbox"/> 5 |
| Citizen or Subject of a Foreign Country | <input type="checkbox"/> 3 | <input type="checkbox"/> 3 | Foreign Nation | <input type="checkbox"/> 6 | <input type="checkbox"/> 6 |

IV. ORIGIN
AMENDED
☒ Original Proceeding

(PLACE AN "X" IN ONE BOX ONLY)

- ☐ Removed from State Court
- ☐ Remanded from Appellate Court
- ☐ Reinstated or Reopened
- ☐ Transferred from Another district (specify)
- ☐ Multidistrict Litigation
- ☐ Appeal to District Judge from Magistrate Judgment

V. NATURE OF SUIT (PLACE AN "X" IN ONE BOX ONLY)

CONTRACT	TORTS	FORFEITURE/PENALTY	BANKRUPTCY	OTHER STATUTES
<input type="checkbox"/> 110 Insurance <input type="checkbox"/> 120 Marine <input type="checkbox"/> 130 Miller Act <input type="checkbox"/> 140 Negotiable Instrument <input type="checkbox"/> 150 Recovery of Overpayment & Enforcement of Judgment <input type="checkbox"/> 151 Medicare Act <input type="checkbox"/> 152 Recovery of Defaulted Student Loans (Excl Veterans) <input type="checkbox"/> 153 Recovery of Overpayment of Veteran's Benefits <input type="checkbox"/> 160 Stockholders Suits <input type="checkbox"/> 190 Other Contract <input type="checkbox"/> 195 Contract Product Liability <input type="checkbox"/> 196 Franchise	PERSONAL INJURY <input type="checkbox"/> 310 Airplane <input type="checkbox"/> 315 Airplane Product Liability <input type="checkbox"/> 320 Assault Libel & Slander <input type="checkbox"/> 330 Federal Employers Liability <input type="checkbox"/> 340 Marine <input type="checkbox"/> 345 Marine Product Liability <input type="checkbox"/> 350 Motor Vehicle <input type="checkbox"/> 355 Motor Vehicle Product Liability <input type="checkbox"/> 360 Other Personal Injury PERSONAL INJURY <input type="checkbox"/> 362 Personal Injury Med Malpractice <input type="checkbox"/> 365 Personal Injury Product Liability <input type="checkbox"/> 368 Asbestos Personal Injury Product Liability PERSONAL PROPERTY <input type="checkbox"/> 370 Other Fraud <input type="checkbox"/> 371 Truth in Lending <input type="checkbox"/> 380 Other Personal Property Damage <input type="checkbox"/> 385 Property Damage Product Liability	<input type="checkbox"/> 610 Agriculture <input type="checkbox"/> 620 Other Food & Drug <input type="checkbox"/> 625 Drug Related Seizure of Property 21 USC 881 <input type="checkbox"/> 630 Liquor Laws <input type="checkbox"/> 640 RR & Truck <input type="checkbox"/> 650 Airline Regs <input type="checkbox"/> 660 Occupational Safety/Health <input type="checkbox"/> 690 Other LABOR <input type="checkbox"/> 710 Fair Labor Standards Act <input type="checkbox"/> 720 Labor/Mgmt Relations <input type="checkbox"/> 730 Labor/Mgmt Reporting & Disclosure Act <input type="checkbox"/> 740 Railway Labor Act <input type="checkbox"/> 790 Other Labor Litigation <input type="checkbox"/> 791 EmpLRet. Inc. Security Act	<input type="checkbox"/> 422 Appeal 28 USC 158 <input type="checkbox"/> 423 Withdrawal 28 USC 157 PROPERTY RIGHTS <input type="checkbox"/> 820 Copyrights <input type="checkbox"/> 830 Patent <input type="checkbox"/> 840 Trademark SOCIAL SECURITY <input type="checkbox"/> 861 HIA (1396f) <input type="checkbox"/> 862 Black Lung (923) <input type="checkbox"/> 863 DIWC/DIWW (405(g)) <input type="checkbox"/> 864 SSID Title XVI <input type="checkbox"/> 865 RSI (405(g)) FEDERAL TAX SUITS <input type="checkbox"/> 870 Taxes (US Plaintiff or Defendant) <input type="checkbox"/> 871 IRS - Third Party 26 USC 7609	<input type="checkbox"/> 400 State Reapportionment <input type="checkbox"/> 410 Antitrust <input type="checkbox"/> 430 Banks and Banking <input type="checkbox"/> 450 Commerce/ICC Rates/etc. <input type="checkbox"/> 460 Deportation <input type="checkbox"/> 470 Racketeer Influenced and Corrupt Organizations <input type="checkbox"/> 810 Selective Service <input type="checkbox"/> 850 Securities/Commodities/Exchange <input type="checkbox"/> 875 Customer Challenge 12 USC 3410 <input type="checkbox"/> 891 Agricultural Acts <input type="checkbox"/> 892 Economic Stabilization Act <input type="checkbox"/> 893 Environmental Matters <input type="checkbox"/> 894 Energy Allocation Act <input type="checkbox"/> 895 Freedom of Information Act <input type="checkbox"/> 900 Appeal of Fee Determination Under Equal Access to Justice <input type="checkbox"/> 950 Constitutionality of State Statutes <input type="checkbox"/> 890 Other Statutory Actions
REAL PROPERTY <input type="checkbox"/> 210 Land Condemnation <input type="checkbox"/> 220 Foreclosure <input type="checkbox"/> 230 Rent Lease & Ejectment <input type="checkbox"/> 240 Torts to Land <input type="checkbox"/> 245 Tort Product Liability <input type="checkbox"/> 290 All Other Real Property	CIVIL RIGHTS <input type="checkbox"/> 441 Voting <input type="checkbox"/> 442 Employment <input type="checkbox"/> 443 Housing <input type="checkbox"/> 444 Welfare <input type="checkbox"/> 440 Other Civil Rights <input type="checkbox"/> 445 Amer w/ disab - Empl <input type="checkbox"/> 446 Amer w/ disab - Other <input type="checkbox"/> 480 Consumer Credit <input type="checkbox"/> 490 Cable/Satellite TV	PRISONER PETITIONS <input type="checkbox"/> 510 Motion to Vacate Sentence Habeas Corpus: <input type="checkbox"/> 530 General <input type="checkbox"/> 535 Death Penalty <input type="checkbox"/> 540 Mandamus & Other <input checked="" type="checkbox"/> 550 Civil Rights <input type="checkbox"/> 555 Prison Condition		

VI. CAUSE OF ACTION (CITE THE US CIVIL STATUTE UNDER WHICH YOU ARE FILING AND WRITE BRIEF STATEMENT OF CAUSE. DO NOT CITE JURISDICTIONAL STATUTES UNLESS DIVERSITY)

VII. REQUESTED IN COMPLAINT: ☐ CHECK IF THIS IS A CLASS ACTION DEMAND \$ 30,000 CHECK YES only if demanded in complaint:
 UNDER F.R.C.P. 23 JURY DEMAND: ☐ YES ☒ NO

VIII. RELATED CASE(S) IF ANY PLEASE REFER TO CIVIL L.R. 3-12 CONCERNING REQUIREMENT TO FILE "NOTICE OF RELATED CASE".

IX. DIVISIONAL ASSIGNMENT (CIVIL L.R. 3-2)

(PLACE AND "X" IN ONE BOX ONLY)

☐ SAN FRANCISCO/OAKLAND☐ SAN JOSE

DATE

SIGNATURE OF ATTORNEY OF RECORD

E. Gutierrez
 PLAINTIFF

"AMENDED COMPLAINT."COMPLAINT BY A PRISONER UNDER THE CIVIL RIGHTS ACT, 42 U.S.C §§ 1983Name GUTIERREZ EDWARD

(Last) (First) (Initial)

Prisoner Number BGJ774 / 06083690Institutional Address 150 W. HEDDING ST.SAN JOSE, CA. 95110.UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIAEDWARD GUTIERREZ, SR.

(Enter the full name of plaintiff in this action.)

vs.

DR. ALEXANDER CHYORNY,
LORI HORN, R.N., DR. JOHN C. LUKRICH,
DR. MARIA JUAREZ-REYES,
DR. ANITA GADDIPATI, DR. G. VERALES,
% WARFIELD #2642, EDWARD C. FLORES,
CAPTAIN D. SEPULVEDA.Case No. C07-4251 MMC (PR)
(To be provided by the clerk of court)COMPLAINT UNDER THE
CIVIL RIGHTS ACT,
42 U.S.C §§ 1983
AMENDED COMPLAINT.

(Enter the full name of the defendant(s) in this action))

*[All questions on this complaint form must be answered in order for your action to proceed..]*I. Exhaustion of Administrative Remedies**[Note:** You must exhaust your administrative remedies before your claim can go forward. The court will dismiss any unexhausted claims.]A. Place of present confinement SANTA CLARA COUNTY
DEPARTMENT OF CORRECTIONS

B. Is there a grievance procedure in this institution?

YES ☒ NO ()

C. Did you present the facts in your complaint for review through the grievance procedure?

YES ☒ NO ()

D. If your answer is YES, list the appeal number and the date and result of the

COMPLAINT

- 1 -

appeal at each level of review. If you did not pursue a certain level of appeal, explain why.

1. Informal appeal 1. NUMBER 69057 DATE: 4-16-07.

2. NUMBER 69493 DATE: 5-25-07.

(SEE EXHIBIT 1.)

2. First formal level "REFER TO MEDICAL"

3. Second formal level "SEE RESPONSE BELOW"

4. Third formal level YOU WERE SEEN 6-19-07.

BUT NOTHING DONE.

E. Is the last level to which you appealed the highest level of appeal available to you?

YES ☒ NO ()

F. If you did not present your claim for review through the grievance procedure, explain why. I DID PRESENT MY CLAIM...

II. Parties

A. Write your name and your present address. Do the same for additional plaintiffs, if any.

EDWARD GUTIERREZ, SR., 06083690

150 W. HEDDING ST.

SAN JOSE, CA. 95110

B. Write the full name of each defendant, his or her official position, and his or her

place of employment.

DR. ALEXANDER CHYORNY, CHIEF DOCTOR, 150 W. HEDDING ST. S.J. CAL. 95110.
 LORI HORN, R.N., HEAD NURSE, 150 W. HEDDING ST. SAN JOSE, CAL. 95110.
 DR. JOHN C. LURRICH, DOCTOR, 150 W. HEDDING ST. SAN JOSE CAL. 95110
 DR. MARIA JUAREZ-REYES, DOCTOR, 150 W. HEDDING ST. SAN JOSE, CAL. 95110
 DR. ANITA GADDIPATI, DOCTOR, 150 W. HEDDING ST. SAN JOSE, CAL. 95110
 DR. G. VERSALES, DOCTOR, 150 W. HEDDING ST. SAN JOSE CAL. 95110
 C/O WARFIELD #2642, CORRECTION OFFICER, 150 W. HEDDING ST. S. J. CAL. 95110
 EDWARD C. FLORES, CHIEF OF CORRECTIONS, 150 W. HEDDING ST. S.J. CAL. 95110
 CAPTAIN D. SEPULVEDA JAIL COMMANDER, 150 W. HEDDING ST. S.J. CAL. 95110 III.

Statement of Claim

State here as briefly as possible the facts of your case. Be sure to describe how each defendant is involved and to include dates, when possible. Do not give any legal arguments or cite any cases or statutes. If you have more than one claim, each claim should be set forth in a separate numbered paragraph.

I HAVE BEEN ENCARCERATED IN THIS SANTA CLARA COUNTY DEPARTMENT OF CORRECTION SINCE 12-13-'06. I HAVE REQUESTED MEDICAL ATTENTION FOR A LIVER ILLNESS THAT I HAVE HAD SINCE 1997. I HAVE PUT IN SEVERAL MEDICAL REQUEST FORMS AND GRIEVANCES, (PLEASE SEE EXHIBIT 1). ALL ATTEMPTS HAVE BEEN FUTILE.

THE FOLLOWING INDIVIDUALS ARE DIRECTLY RESPONSIBLE FOR THIS DELIBERATE INDIFFERENCE:

#1. DR. ALEXANDER CHYORNY IS CHIEF MEDICAL DOCTOR AND RESPONSIBLE FOR HIS MEDICAL DEPARTMENT, AND OTHER DOCTORS TO PROVIDE TREAT- (PLEASE SEE SUPPLEMENTAL).

IV. Relief

Your complaint cannot go forward unless you request specific relief. State briefly exactly what you want the court to do for you. Make no legal arguments; cite no cases or statutes.

SEE PAGE -4- A.

CASE NO. 07-4251 MMC (PR)

STATEMENT OF CLAIM...
SUPPLEMENTAL.

MENT. HE SHOULD HAVE A PROCEDURE TO ENSURE THAT INMATES ARE MEDICALLY TREATED AND NOT DELIBERATELY NEGLECTED... ESPECIALLY WHEN COMPLAINTS (GRIEVANCES, SEE EXHIBIT 1.) ARE LODGED AGAINST HIS DOCTORS AND MEDICAL DEPARTMENT.

#2. LORI HORN, R.N., IS THE HEAD NURSE, HERE AT SANTA CLARA D.O.C. MEDICAL DEPARTMENT AND IS RESPONSIBLE FOR NURSES; AND THEIR RESCHEDULING MY DOCTOR'S APPOINTMENTS APPROXIMATELY 13 TIMES OUT OF 16 MEDICAL REQUEST FORMS AND 3 GRIEVANCES. (PLEASE SEE EXHIBIT 1.) I WAS ONLY SEEN 4 TIMES AND NOTHING WAS DONE TO TREAT MY ILLNESS.

#3.: DR. JOHN C. LUKRICH, DR. MARIA JUAREZ-REYES, DR. ANITA GADDIPATI, AND DR. G. VERSALES ARE ALL DIRECTLY RESPONSIBLE FOR REFUSING TO DIAGNOSE AND TREAT MY CHRONIC LIVER ILLNESS. I HAVE ASKED THEM CONTINUOUSLY TO "PLEASE" TREAT MY ILLNESS OF THE LIVER (SEE EXHIBIT 1.) THERE IS A TREATMENT FOR THIS PROBLEM BUT ALL PARTIES REFUSE TO PROVIDE ME WITH THE AVAILABLE TREATMENT STATING THAT TO "WAIT UNTIL YOUR LIVER GETS BAD." [SIC]

CASE NO. C07-4251MMC (PR)

STATEMENT OF CLAIM...
SUPPLEMENTAL.

IT IS COMMON KNOWLEDGE THAT ONCE SOMEONE'S LIVER "GOES BAD" A PERSON DIES. I HAVE HAD THIS ILLNESS FOR APPROXIMATELY 11 YEARS AND I KNOW THAT MY LIVER IS NOT HEALTHY; "GOING BAD" OR "BAD". WHY SHOULD I WAIT UNTIL I'M DEAD TO BE GIVEN ATTENTION?....

#4. % WARFIELD #2642 IS RESPONSIBLE FOR GETTING INMATES AND MEDICAL REQUEST FORMS TO AN ASSESSMENT NURSE BY WAY OF ANNOUNCING NURSE'S PRESENCE TO INMATES; PER ENTIRE JAIL PROCEDURE FOR THE LAST 20 YEARS... INSTEAD HE FORCES NURSE TO LEAVE AND STATES THAT WE MUST STICK MEDICAL REQUEST FORMS OUT OUR CELL DOOR. WHEN WE DO THIS OFFICER, WARFIELD STILL FORCES NURSE TO LEAVE AND TELLS INMATES THAT WE ARE TO PUT OUT THE FORMS THE NIGHT BEFORE. HIS BAILIWICK IS NOT TO ARBITRARILY CHANGE JAIL PROCEDURES WITHOUT CONSENT FROM THE CHAIRMAN OF THE CORRECTIONAL STANDARDS AUTHORITY.

#5. EDWARD C. FLORES, CHIEF OF CORRECTIONS, AND CAPTAIN D. SEPULVEDA, JAIL COMMANDER ARE RESPONSIBLE FOR THE JAIL, IT'S STAFF, AND THE

CASE NO. C07-4251MMCCPR)


STATEMENT OF CLAIM...

SUPPLEMENTAL.

MEDICAL DEPARTMENT; THEREBY ALSO RESPONSIBLE FOR THE HEALTH AND WELL BEING OF JAIL INMATES AND THE GRIEVENCE PROCEDURE AND/OR THE SIGNIFICANCE OF THE GRIEVENCE PROCEDURE.

NOTE: FOR THE PAST 3-4 MONTHS THE MEDICAL STAFF HAVE ASKED ME TO TAKE A T. B. (P.P.T.), SKIN TEST, APPROXIMATELY 13 TIMES. I HAVE REFUSED TO TAKE THIS TEST AND INSTEAD GAVE THEM A CHEST-X-RAY. AND THEY CONTINUE TO ASK... THIS IS, NO DOUBT, TO APPEAR AS THOUGH I AM REFUSING MEDICAL-TREATMENT AS THEY DO NOT ASK ANY OF THE OTHER 1000 INMATES AND THE MEDICAL DEPARTMENT STARTED THIS AT THE TIME IN WHICH THEY WERE MADE AWARE OF THIS PENDING COMPLAINT.

DATE:

SIGNED: 
EDWARD GUTIERREZ
PLAINTIFF.

1 RELIEF: 1-2-3-4...

2 1. REQUEST MEDICAL TREATMENT; BY WAY
3 OF COURT ORDER FOR: OUTSIDE FACILITY (VALLY
4 MEDICAL CENTER). THIS SANTA CLARA COUNTY
5 DEPARTMENT OF CORRECTION MEDICAL DEPARTMENT
6 (PLEASE SEE RELIEF SUPPLEMENTAL 4:A-B-C.)

7 I declare under penalty of perjury that the foregoing is true and correct.

8
9 Signed this SEE day of SUPPLEMENTAL

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11 

12 (Plaintiff's signature)
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CASE No. C07-4251 MMC(PR)

RELIEF SUPPLEMENTAL.

1
2 IS A SUBSIDIARY OF VALLY MEDICAL CENTER AND
3 THEREFOR CAN CONTINUE ANY PLAN OF ACTION
4 INITIATED BY VALLY MEDICAL CENTER; THIS
5 SAME ORDER SHOULD INCLUDE THE SANTA CLARA
6 COUNTY DEPARTMENT OF CORRECTION AND IT'S
7 MEDICAL DEPARTMENT TO CONTINUE SAID TREAT-
8 MENT UNTIL COMPLETED.

9
10 2. AS SHOWN BY EXHIBITS 1 AND 2 IT
11 WILL BE VIRTUALLY IMPOSSIBLE FOR ME TO
12 SUCCESSFULLY PROSECUTE THIS CIVIL MATTER...
13 THERE ARE FAR TOO MANY OBSTACLES AND/OR
14 COMPLETE BLOCKS AS SHOWN IN EXHIBIT 2.
15 THEREFORE I REQUEST ASSISTANCE BY A COURT
16 APPOINTED COUNSEL OR INVESTIGATOR.

17
18 3. PLAINTIFF ALSO REQUESTS MONETARY
19 ORDER OF \$30,000 FOR MENTAL, PHYSICAL
20 SUFFERING, AND DAMAGE TO LIVER BROUGHT
21 ON BY THIS DELIBERATE INDIFFERENCE.

22
23 4. AND/OR THE ALTERNATIVE "FIX-ALL" OF:
24 ORDERING A CHANGE OF VENUE FOR MY
25 CRIMINAL CASE; TO BE MOVED TO SAN FRANCISCO
26 IN ORDER TO ELIMINATE THE DIFFICULTIES
27 AND OBSTACLES OF SUCCESSFULLY PROSECUTING
28

CASE NO. C07-4251MMC(PR)

RELIEF SUPPLEMENTAL.

THIS CASE. AND AT THE SAME PLACE RECIEVE
MEDICAL TREATMENT WITHOUT ALL OF THE
INTENTIONAL AND UNINTENTIONAL PROBLEMS AND
DELIBERATE INDIFFERENCE SHOWN IN EXHIBITS
1. AND 2. OF THIS AMMENDED COMPLAINT...
A CHANGE OF VENUE (ON CRIMINAL CASE)
WOULD GIVE RELIEF TO ALL ISSUES ABOVE.

I DECLARE UNDER PENALTY OF PERJURY THAT THE
FOREGOING IS TRUE AND CORRECT.

DATE SIGNED: _____

SIGNED: Ed. Gutierrez
EDWARD GUTIERREZ
PLAINTIFF.

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

EDWARD GUTIERREZ

Plaintiff,

vs.

DR. ALEXANDER CHYORNY,
et al.

Defendant (s)

CASE NO. C07 4251 MMC (P.R.)

PRISONER'S
APPLICATION TO PROCEED
IN FORMA PAUPERIS

AMENDED COMPLAINT...

I, EDWARD GUTIERREZ, declare, under penalty of perjury that I am the plaintiff in the above entitled case and that the information I offer throughout this application is true and correct. I offer this application in support of my request to proceed without being required to prepay the full amount of fees, costs or give security. I state that because of my poverty I am unable to pay the costs of this action or give security, and that I believe that I am entitled to relief.

In support of this application, I provide the following information:

I. Are you presently employed? Yes ___ No X

If your answer is "yes," state both your gross and net salary or wages per month, and give the name and address of your employer:

Gross: _____ Net: _____

Employer: _____

1 If the answer is "no," state the date of last employment and the amount of the gross and net
 2 salary and wages per month which you received. (If you are imprisoned, specify the last
 3 place of employment prior to imprisonment.)
 4 _____
 5 _____
 6 _____

7 2. Have you received, within the past twelve (12) months, any money from any of the
 8 following sources:

- 9 a. Business, Profession or Yes ___ No X
 10 self employment
 11 b. Income from stocks, bonds, Yes ___ No X
 12 or royalties?
 13 c. Rent payments? Yes ___ No X
 14 d. Pensions, annuities, or Yes ___ No X
 15 life insurance payments?
 16 e. Federal or State welfare payments, Yes ___ No X
 17 Social Security or other govern-
 18 ment source?

19 If the answer is "yes" to any of the above, describe each source of money and state the amount
 20 received from each.
 21 _____
 22 _____

23 3. Are you married? Yes ___ No X

24 Spouse's Full Name: _____

25 Spouse's Place of Employment: _____

26 Spouse's Monthly Salary, Wages or Income:

27 Gross \$ 0 — Net \$ 0 —

28 4. a. List amount you contribute to your spouse's support: \$ 0 —

1 b. List the persons other than your spouse who are dependent upon you for
 2 support and indicate how much you contribute toward their support. (NOTE:
 3 For minor children, list only their initials and ages. DO NOT INCLUDE
 4 THEIR NAMES.).
 5 _____
 6 _____

7 5. Do you own or are you buying a home? Yes ____ No X
 8 Estimated Market Value: \$ _____ Amount of Mortgage: \$ _____
 9 6. Do you own an automobile? Yes ____ No X
 10 Make _____ Year _____ Model _____
 11 Is it financed? Yes ____ No ____ If so, Total due: \$ _____
 12 Monthly Payment: \$ _____
 13 7. Do you have a bank account? Yes ____ No X (Do not include account numbers.)
 14 Name(s) and address(es) of bank: _____
 15 _____
 16 Present balance(s): \$ _____
 17 Do you own any cash? Yes ____ No ____ Amount: \$ _____
 18 Do you have any other assets? (If "yes," provide a description of each asset and its estimated
 19 market value.) Yes ____ No X
 20 _____

21 8. What are your monthly expenses?
 22 Rent: \$ _____ Utilities: _____
 23 Food: \$ _____ Clothing: _____
 24 Charge Accounts:
 25

<u>Name of Account</u>	<u>Monthly Payment</u>	<u>Total Owed on This Acct.</u>
26 _____	\$ _____	\$ _____
27 _____	\$ _____	\$ _____
28 _____	\$ _____	\$ _____

 9. Do

1 you have any other debts? (List current obligations, indicating amounts and to whom they are
2 payable. Do not include account numbers.)
3 _____
4 _____

5 10. Does the complaint which you are seeking to file raise claims that have been presented
6 in other lawsuits? Yes ____ No X **AMENDED COMPLAINT.**

7 Please list the case name(s) and number(s) of the prior lawsuit(s), and the name of the court in
8 which they were filed.
9 _____
10 _____

11 I consent to prison officials withdrawing from my trust account and paying to the court
12 the initial partial filing fee and all installment payments required by the court.

13 I declare under the penalty of perjury that the foregoing is true and correct and
14 understand that a false statement herein may result in the dismissal of my claims.
15 _____

16 _____
17 DATE

18 
19 _____
20 SIGNATURE OF APPLICANT
21
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Case Number: NO. 007 4251 MMC (PR)
AMENDED COMPLAINT.

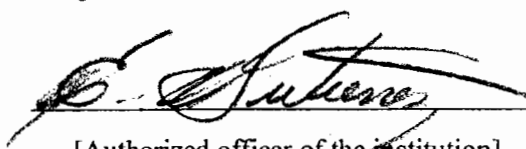
CERTIFICATE OF FUNDS
IN
PRISONER'S ACCOUNT

I certify that attached hereto is a true and correct copy of the prisoner's trust account statement showing transactions of EDWARD GUTIERREZ, for the last six months at

[prisoner name]
SANTA CLARA COUNTY D.O.C. where (s)he is confined.
[name of institution]

I further certify that the average deposits each month to this prisoner's account for the most recent 6-month period were \$ AMENDED and the average balance in the prisoner's account each month for the most recent 6-month period was \$ AMENDED.

Dated: _____


[Authorized officer of the institution]

31483 CIVIL COMPLAINT

DS
Main Jail ☒
Main Jail South ☐
North County Jail ☐

SANTA CLARA COUNTY DEPARTMENT OF CORRECTION
INMATE GRIEVANCE FORM

Elmwood ☐
CCW ☐
MRC ☐

69493

INMATE'S EDWARD GUTIERREZ
NAME:

BOOKING 06083690
NUMBER:

HOUSING 4B-1-07
UNIT:

DETAILS OF GRIEVANCE. PRINT! BE SPECIFIC! I HAVE BEEN TRYING TO GET MEDICAL ATTENTION FOR FIVE MONTHS TO NO AVAIL. I HAVE HAD 6 APPOINTMENTS CANCELED. I NEED BLOOD WORK FOR LIVER FUNCTION AS I AM VERY SICK. ALSO, FOLLOW UP ON PRE-CANCEROUS SURGERY.

WHAT SOLUTION ARE YOU RECOMMENDING?: I NEED MEDICAL ATTENTION.

Your Signature: E. Gutierrez Date: 5/25/07 Time: 6:00 AM ☒ PM
(Do NOT write below this line. Use additional sheets if necessary)

Received from Inmate on:
Day: SAT. Date: 5/26/07 Time: 0631 officer: WARFIELD 2642 Team: B

RESPONDING OFFICER'S STATEMENT (Please print): I AM UNAWARE OF ANY CANCELED
PTS, SURGERIES, or illness. PLEASE forward to medical

☐ Resolved ☒ Refer to Level II

Officer's Name: WARFIELD 2642 Team: B Date: 5/26/07

SUPERVISOR'S ACTION: See response below.

☒ Resolved ☐ Refer to Level III

Supervisor's Name: _____ Team: _____ Date: ____/____/____

SHIFT SUPERVISOR REVIEW: ☐ Concur ☐ Reversed

SIGNATURE: _____ Date: ____/____/____ Time: _____

SUPPORT SERVICE RESPONSE: Unit Assigned: Medical Date Assigned: ____/____/____
Date Due: 06/01/07

You were seen & examined on 6-19-07
after lab + some green you will be seen
again by the Dr.

Response by: [Signature] Title: _____ Date: 6/22/07 Time: _____

FACILITY COMMANDER/DESIGNEE REVIEW: ☒ Concur ☐ Reversed

SIGNATURE: [Signature] Date: 6/26/07 Time: 1552

RESPONSE RETURNED TO INMATE: Date: 06/27/07 Time: _____ By: [Signature]
Distribution: White-Administration Canary-Inmate (Final Disposition) Pink-Inmate (Initial Receipt)

Main Jail []
Main Jail South []
North County Jail []

SANTA CLARA COUNTY DEPARTMENT OF CORRECTION
INMATE GRIEVANCE FORM

Elmwood []
CCW []
WRC []

BAT 774

69057

INMATE'S NAME: EDWARD GUTIERREZ

BOOKING NUMBER: 06083690

HOUSING UNIT: 4B-1-15

DETAILS OF GRIEVANCE. PRINT! BE SPECIFIC!: I HAD A MEDICAL APPOINTMENT FOR 4-12-07 THIS IS THE 10TH. TIME I HAVE BEEN RESCHEDULED FOR MEDICAL ATTENTION... SUCH DELIBERATE-INDIFFERENCE IS NOT IN ANYWAY CLOSE TO LEGAL AND/OR CIVILIZED.

WHAT SOLUTION ARE YOU RECOMMENDING?: VERY LONG...

Your Signature: [Signature] Date: 4/16/07 Time: 8:00 AM/PM
(Do NOT write below this line. Use additional paper if necessary.)

Received from Inmate on:
Day: Mon Date: 4/16/07 Time: 2215 Officer: HAMMOND #2662 Team: C

RESPONDING OFFICER'S STATEMENT (Please print): WILL REFER TO MEDICAL

[] Resolved ☒ Refer to Level II

Officer's Name: HAMMOND Team: C Date: 4/16/07

SUPERVISOR'S ACTION: See response below.

[X] Resolved [] Refer to Level III

Supervisor's Name: _____ Team: _____ Date: _____

SHIFT LIEUTENANT REVIEW: [] Concur [] Reversed

APR 19 2007 AM 11:40

SIGNATURE: _____ Date: _____ Time: _____

SUPPORT SERVICE RESPONSE: Unit Assigned: Medical Date Assigned: 1/1
Date Due: 04/23/07

6-22-07 you have seen this on 6-19-07
also on 6-26-07 you will be seen again after
lat + some.

Response by: [Signature] Title: _____ Date: 6/22/07 Time: _____

FACILITY COMMANDER/DESIGNEE REVIEW: [X] Concur [] Reversed

TOOK 2 MONTHS TO ANSWER. E.H.

SIGNATURE: _____ Date: 6/26/07 Time: 1553

RESPONSE RETURNED TO INMATE: Date: 06/27/07 Time: _____ By: _____
Distribution: White-Administration Capacity-Inmate (Final Disposition) Pink-Inmate (Initial Receipt)



ADULT CUSTODY HEALTH SERVICES
WHITE CARD / CARTA BLANCA

Housing/Vivienda 4B-1-15 Date/Fecha 3-15-07

Request to see (Circle One): Medical Mental Health Dental
 Quiero ver a alguien en (Marque Uno): Servicios Medicos Servicios de Salud Mental Servicios Dental

PFN # BGJ774 Booking #/Numero del Registro de Admision 06083690

Name/Nombre GUTIERREZ EDWARD S
 Last Name (Apellido Paterno) First (Nombre de Pila) Middle (Segundo Nombre)

Date of Birth/Fecha de Nacimiento 10-23-59

Reason(s) for Request/Razon(es) de esta peticion: THERE IS SOMETHING WRONG WITH MY BLOOD, EFFECTING MY HLART, BRAIN, KIDNEYS AND MUSCLE TISSUE... LIKE TO BE WEIGHED.
 How Long Have You Had This Problem(s)? ¿Por cuanto tiempo ha tenido usted esta problema(s)? 10 YEARS.

NOTE: GIVE THIS FORM ONLY TO A NURSE.

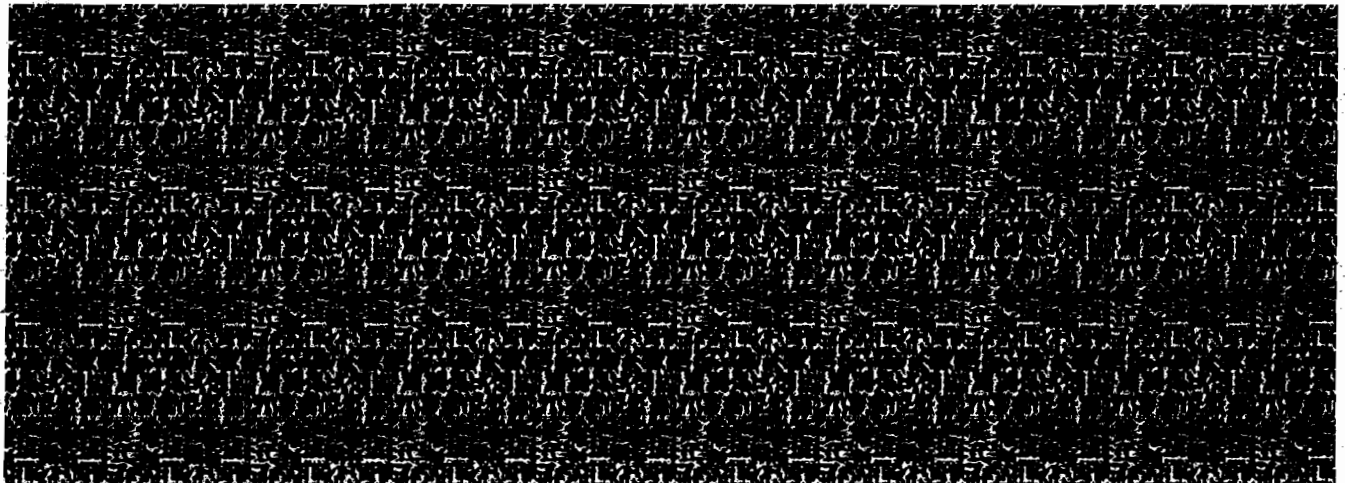
NOTICIA: SOLAMENTE DEBE ENTREGAR ESTE FORMULARIO A UNA ENFERMERA.

***** DO NOT WRITE BELOW THIS LINE. NO ESCRIBA ABAJO DE ESTA LINA. *****

DATE NURSE RECEIVED WHITE CARD FROM PATIENT: 3/19/07

NURSE'S INITIALS: HL

ASSESSMENT:



P ☐ The following medication(s) may help you and are available through the Commissary/
 La siguiente medicina(s) podria ayudarle y estan disponibles en la Comisaria:

☐ Physician will review your request / El doctor revisara su peticion

☒ MD Appointment Scheduled / Cita para ver al doctor (week of / la semana de) 4/12/07 AML

☐ Psych MD Appointment Scheduled / Cita para ver al ciciatra (week of / la semana de)

☒ Dental Appointment Scheduled / Cita para ver al dentista (week of / la semana de) 3/21/07

☐ Mental Health will see you / Departamento de Salud Mental te van a ver

☐ No Sleep Medications are given at the Adult Custody Facilities / El la Custodia de Adultos no dan medicina para dormir.

☐ Other Plan of Action / Comments / Otro Plan de Accion

☐ Patient Health Education Provided Explain:

☐ Medical Authorization Form completed

☐ Medical Wristband completed

☐ Standardized Procedure started; if yes, name(s) of Standardized Procedure(s) initiated:

DATE RESPONSE SENT TO PATIENT 3/19/07 RN SIGNATURE HL

DATE RESPONSE SENT TO
 PATIENT WITH MD INFORMATION RN SIGNATURE



ADULT CUSTODY HEALTH SERVICES
WHITE CARD / CARTA BLANCA

Housing/Vivienda 4B 1 15 Date/Fecha 4-13-07
Request to see (Circle One): Medical Mental Health Dental
Quiero ver a alguien en (Marque Uno): Servicios Medicos Servicios de Salud Mental Servicios Dental
PFN # BCJ 774 Booking #/Numero del Registro de Admision 06083690
Name/Nombre GUTIERREZ EDWARD
Last Name (Apellido Paterno) First (Nombre de Pila) Middle (Segundo Nombre)

Date of Birth/Fecha de Nacimiento 10 23 59

Reason(s) for Request/Razon(es) de esta peticion:

4-12-07 10th TIME APPOINTMENT FOR RESCHEDULED!

How Long Have You Had This Problem(s)? / Por cuanto tiempo ha tenido usted esta problema(s)? TOO LONG!

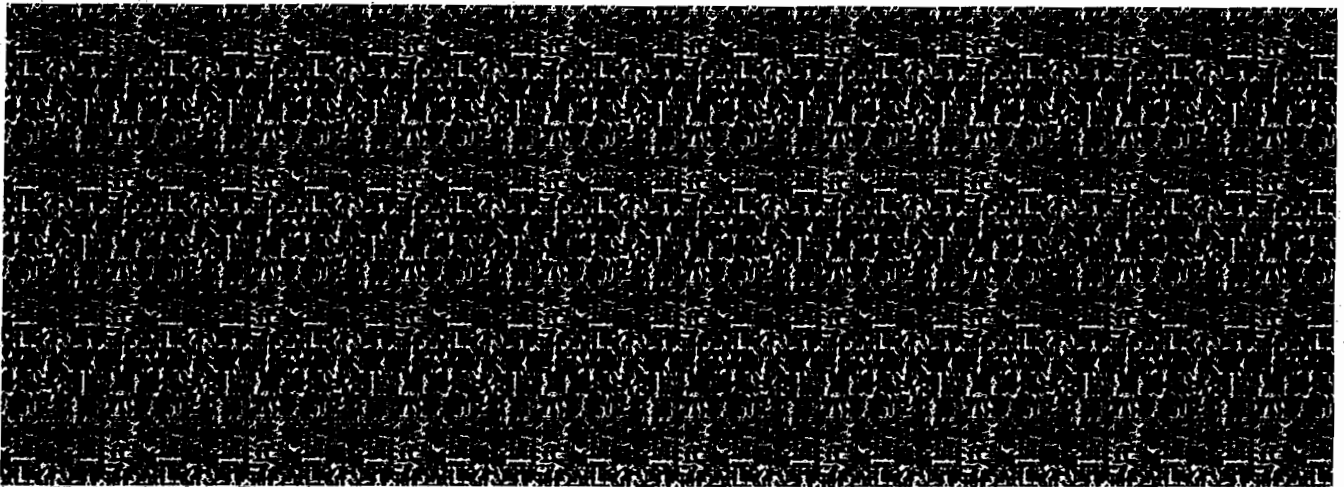
NOTE: GIVE THIS FORM ONLY TO A NURSE.

NOTICIA: SOLAMENTE DEBE ENTREGAR ESTE FORMULARIO A UNA ENFERMERA.

***** DO NOT WRITE BELOW THIS LINE. NO ESCRIBA ABAJO DE ESTA LINA. *****

DATE NURSE RECEIVED WHITE CARD FROM PATIENT: 4/16/07 NURSE'S INITIALS: h

ASSESSMENT:



- P ☐ The following medication(s) may help you and are available through the Commissary/
La siguiente medicina(s) podria ayudarle y estan disponibles en la Comisaria:
- ☐ Physician will review your request / El doctor revisara su peticion
- ☒ MD Appointment Scheduled / Cita para ver al doctor (week of / la semana de) 5/9/07
- ☐ Psych MD Appointment Scheduled / Cita para ver al ciciatra (week of / la semana de)
- ☐ Dental Appointment Scheduled / Cita para ver al dentista (week of / la semana de)
- ☐ Mental Health will see you / Departamento de Salud Mental te van a ver
- ☐ No Sleep Medications are given at the Adult Custody Facilities / El la Custodia de Adultos no dan medicina para dormir.
- ☐ Other Plan of Action / Comments / Otro Plan de Accion

☐ Patient Health Education Provided Explain:

☐ Medical Authorization Form completed ☐ Medical Wristband completed

☐ Standardized Procedure started; if yes, name(s) of Standardized Procedure(s) initiated:

DATE RESPONSE SENT TO PATIENT 4/16/07 RN SIGNATURE [Signature]

DATE RESPONSE SENT TO PATIENT WITH MD INFORMATION RN SIGNATURE

Distribution: White-Medical Record

Pink-Inmate (Initial Receipt)

Yellow-Response to Inmate

Goldenrod-MD Response to Patient

#15



ADULT CUSTODY HEALTH SERVICES
WHITE CARD / CARTA BLANCA

Housing/Vivienda

4B-1-15

4B

Date/Fecha

4-26-07

Request to see (Circle One):

Quiero ver a alguien en (Marque Uno):

Medical
Servicios Medicos

Mental Health
Servicios de Salud Mental

Dental
Servicios Dental

PFN # BGJ 774

Booking #/Numero del Registro de Admision 06083690

Name/Nombre

10-23-59 GUTIERREZ

EDWARD

Last Name (Apellido Paterno)

First (Nombre de Pila)

Middle (Segundo Nombre)

Date of Birth/Fecha de Nacimiento 10-23-59

Reason(s) for Request/Razon(es) de esta peticion: ① I NEED BLOOD WORK FOR LIVER-
FUNCTION... ② ALSO CHECK FOR SYPHILLIS

How Long Have You Had This Problem(s)? ¿Por cuanto tiempo ha tenido usted esta problema(s)? LIVER 10 YRS.

NOTE: GIVE THIS FORM ONLY TO A NURSE.

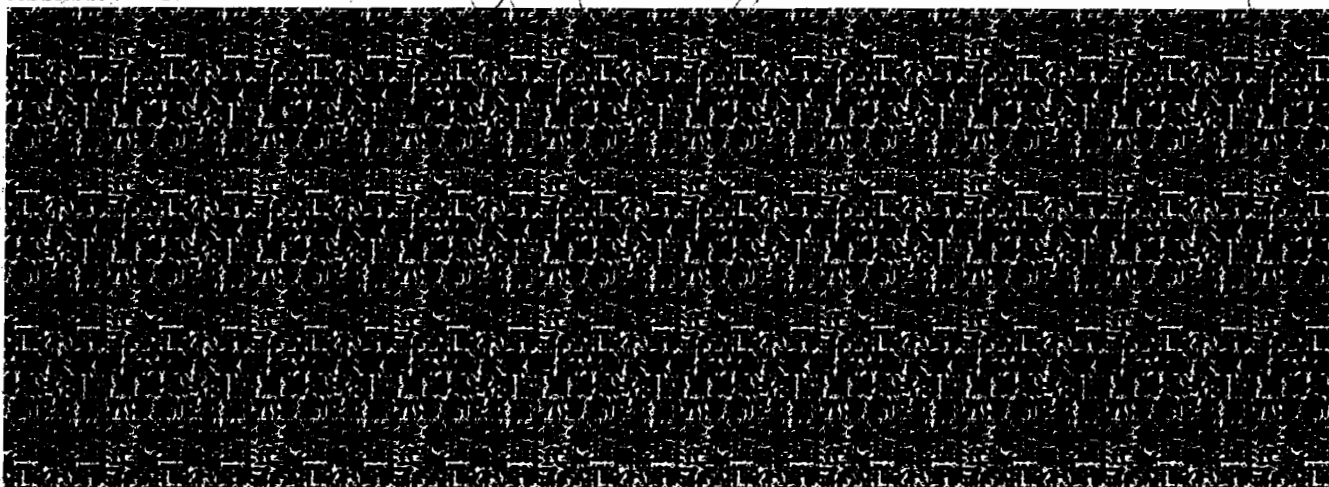
NOTICIA: SOLAMENTE DEBE ENTREGAR ESTE FORMULARIO A UNA ENFERMERA.

DO NOT WRITE BELOW THIS LINE. NO ESCRIBA ABAJO DE ESTA LINEA.

DATE NURSE RECEIVED WHITE CARD FROM PATIENT:

NURSE'S INITIALS:

ASSESSMENT:



P ☐ The following medication(s) may help you and are available through the Commissary/
La siguiente medicina(s) podria ayudarle y estan disponibles en la Comisaria:

☐ Physician will review your request / El doctor revisara su peticion

☒ MD Appointment Scheduled / Cita para ver al doctor (week of / la semana de) 6/1/07

☐ Psych MD Appointment Scheduled / Cita para ver al ciciatra (week of / la semana de)

☐ Dental Appointment Scheduled / Cita para ver al dentista (week of / la semana de)

☐ Mental Health will see you / Departamento de Salud Mental te van a ver

☐ No Sleep Medications are given at the Adult Custody Facilities / El la Custodia de Adultos no dan medicina para dormir.

☐ Other Plan of Action / Comments / Otro Plan de Accion

☐ Patient Health Education Provided Explain:

☐ Medical Authorization Form completed

☐ Medical Wristband completed

☐ Standardized Procedure started; if yes, name(s) of Standardized Procedure(s) initiated:

DATE RESPONSE SENT TO PATIENT

RN SIGNATURE

DATE RESPONSE SENT TO PATIENT WITH MD INFORMATION

4/26/07

RN SIGNATURE

a



ADULT CUSTODY HEALTH SERVICES
WHITE CARD / CARTA BLANCA

Housing/Vivienda 4B-1-15Date/Fecha 5/1/07

Request to see (Circle One):

Medical

Mental Health

Dental

Quiero ver a alguien en (Marque Uno):

Servicios Medicos

Servicios de Salud Mental

Servicios Dental

PFN # BGJ774Booking #/Numero del Registro de Admision 06083690Name/Nombre GUTIERREZEDWARD

Last Name (Apellido Paterno)

First (Nombre de Pila)

Middle (Segundo Nombre)

Date of Birth/Fecha de Nacimiento 10-23-59 I'VE WAITED 4 MONTHS.Reason(s) for Request/Razon(es) de esta peticion: MY APPOINTMENT WAS CANCELED BEFORE IT EVER ARRIVED... I NEED BLOOD WORK A.S.A.P. FOR LIFE THREATENING ILLNESSES... LIVER FUNCTION AND SYPHILIS.How Long Have You Had This Problem(s)? ¿Por cuanto tiempo ha tenido usted esta problema(s)? 10 YRS.

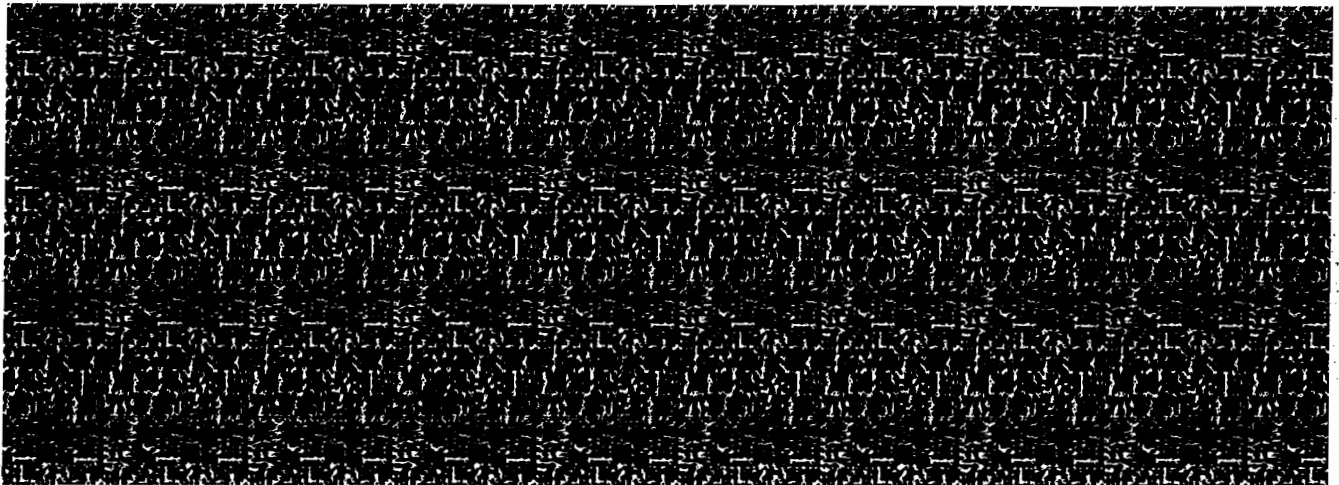
NOTE: GIVE THIS FORM ONLY TO A NURSE.

NOTICIA: SOLAMENTE DEBE ENTREGAR ESTE FORMULARIO A UNA ENFERMERA.

DO NOT WRITE BELOW THIS LINE. NO ESCRIBA ABAJO DE ESTA LINA.

DATE NURSE RECEIVED WHITE CARD FROM PATIENT: 5/3/07NURSE'S INITIALS: n

ASSESSMENT:



P ☐ The following medication(s) may help you and are available through the Commissary/
La siguiente medicina(s) podría ayudarle y están disponibles en la Comisaria:

☐ Physician will review your request / El doctor revisara su peticion

☒ MD Appointment Scheduled / Cita para ver al doctor (week of / la semana de) 6/1/07 updated

☐ Psych MD Appointment Scheduled / Cita para ver al ciciatra (week of / la semana de)

☐ Dental Appointment Scheduled / Cita para ver al dentista (week of / la semana de)

☐ Mental Health will see you / Departamento de Salud Mental te van a ver

☐ No Sleep Medications are given at the Adult Custody Facilities / El la Custodia de Adultos no dan medicina para dormir.

☐ Other Plan of Action / Comments / Otro Plan de Accion

☐ Patient Health Education Provided Explain:

☐ Medical Authorization Form completed

☐ Medical Wristband completed

☐ Standardized Procedure started; if yes, name(s) of Standardized Procedure(s) initiated:

DATE RESPONSE SENT TO PATIENT 5/3/07 RN SIGNATURE [Signature]

DATE RESPONSE SENT TO
PATIENT WITH MD INFORMATION

RN SIGNATURE

Distribution: White-Medical Record

Pink-Inmate (Initial Receipt)

Yellow-Response to Inmate

Goldenrod-MD Response to Patient



ADULT CUSTODY HEALTH SERVICES
WHITE CARD / CARTA BLANCA

Housing/Vivienda

4B-1-B15

Date/Fecha

5-10-07

Request to see (Circle One):

Quiero ver a alguien en (Marque Uno):

Medical

Servicios Medicos

Mental Health

Servicios de Salud Mental

Dental

Servicios Dental

PFN #

BGJ 774

Booking #/Numero del Registro de Admision

06083690

Name/Nombre

GUTIERREZ

EDWARD

Last Name (Apellido Paterno)

First (Nombre de Pila)

Middle (Segundo Nombre)

Date of Birth/Fecha de Nacimiento

10-23-89

Reason(s) for Request/Razon(es) de esta peticion:

I NEED TO TAKE A BLOOD
TEST FOR SYPHILIS... I HAVE BEEN HERE
FOR 5 MONTHS.

How Long Have You Had This Problem(s)? ¿Por cuanto tiempo ha tenido usted esta problema(s)?

LONG TIME

NOTE: GIVE THIS FORM ONLY TO A NURSE.

NOTICIA: SOLAMENTE DEBE ENTREGAR ESTE FORMULARIO A UNA ENFERMERA.

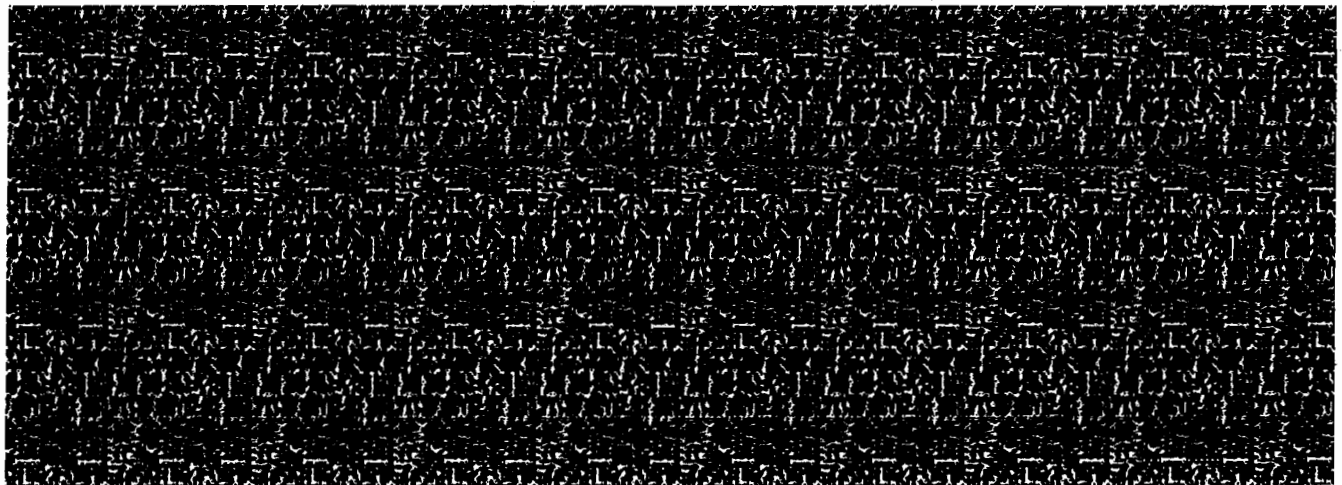
DO NOT WRITE BELOW THIS LINE. NO ESCRIBA ABAJO DE ESTA LINA.

DATE NURSE RECEIVED WHITE CARD FROM PATIENT:

5/15/07

NURSE'S INITIALS: L

ASSESSMENT:



P ☐ The following medication(s) may help you and are available through the Commissary/

La siguiente medicina(s) podria ayudarle y estan disponibles en la Comisaria:

☐ Physician will review your request / El doctor revisara su peticion

☒ MD Appointment Scheduled / Cita para ver al doctor (week of / la semana de)

6/1/07

☐ Psych MD Appointment Scheduled / Cita para ver al ciciatra (week of / la semana de)

☐ Dental Appointment Scheduled / Cita para ver al dentista (week of / la semana de)

☐ Mental Health will see you / Departamento de Salud Mental te van a ver

☐ No Sleep Medications are given at the Adult Custody Facilities / El la Custodia de Adultos no dan medicina para dormir.

☐ Other Plan of Action / Comments / Otro Plan de Accion

☐ Patient Health Education Provided Explain:

☐ Medical Authorization Form completed

☐ Medical Wristband completed

☐ Standardized Procedure started; if yes, name(s) of Standardized Procedure(s) initiated:

DATE RESPONSE SENT TO PATIENT

5/14

RN SIGNATURE

[Signature]

DATE RESPONSE SENT TO
PATIENT WITH MD INFORMATION

RN SIGNATURE

Distribution: White-Medical Record

Pink-Inmate (Initial Receipt)

Yellow-Response to Inmate

Goldenrod-MD Response to Patient



ADULT CUSTODY HEALTH SERVICES
WHITE CARD / CARTA BLANCA

Housing/Vivienda

4B-1-15

Date/Fecha

5-6-07

Request to see (Circle One):

Medical

Mental Health

Dental

Quiero ver a alguien en (Marque Uno):

Servicios Medicos

Servicios de Salud Mental

Servicios Dental

PFN #

BGJ774

Booking #/Numero del Registro de Admision

06083090

Name/Nombre

GUTIERREZ

EDWARD

Last Name (Apellido Paterno)

First (Nombre de Pila)

Middle (Segundo Nombre)

Date of Birth/Fecha de Nacimiento

10-23-59

Reason(s) for Request/Razon(es) de esta peticion:

I HAVE BEEN WAITING 5 MONTHS
FOR MEDICAL TREATMENT... NEED BLOOD WORK FOR LIVER
FUNCTION AND FOR SYPHILIS. CAN'T WAIT ANOTHER MONTH.

How Long Have You Had This Problem(s)? ¿Por cuanto tiempo ha tenido usted esta problema(s)?

10 YRS.

NOTE: GIVE THIS FORM ONLY TO A NURSE.

NOTICIA: SOLAMENTE DEBE ENTREGAR ESTE FORMULARIO A UNA ENFERMERA.

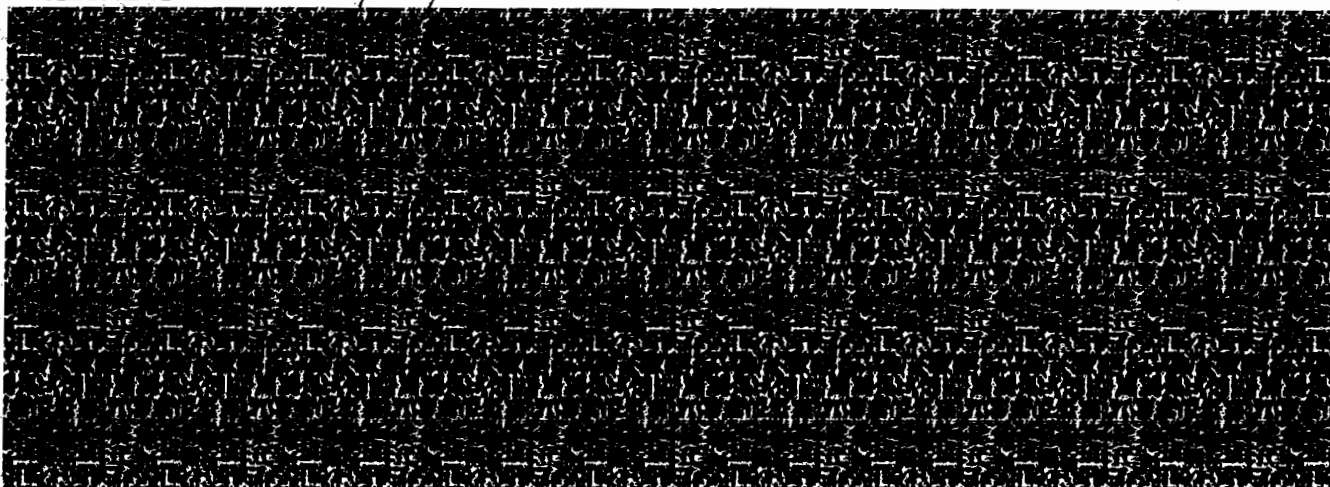
DO NOT WRITE BELOW THIS LINE. NO ESCRIBA ABAJO DE ESTA LINA.

DATE NURSE RECEIVED WHITE CARD FROM PATIENT:

5/7/07

NURSE'S INITIALS:

ASSESSMENT:



P ☐ The following medication(s) may help you and are available through the Commissary/

La siguiente medicina(s) podria ayudarle y estan disponibles en la Comisaria:

☐ Physician will review your request / El doctor revisara su peticion

☒ MD Appointment Scheduled / Cita para ver al doctor (week of / la semana de)

6/1/07 gm

☐ Psych MD Appointment Scheduled / Cita para ver al ciciatra (week of / la semana de)

☐ Dental Appointment Scheduled / Cita para ver al dentista (week of / la semana de)

☐ Mental Health will see you / Departamento de Salud Mental te van a ver

☐ No Sleep Medications are given at the Adult Custody Facilities / El la Custodia de Adultos no dan medicina para dormir.

☐ Other Plan of Action / Comments / Otro Plan de Accion

☐ Patient Health Education Provided Explain:

☐ Medical Authorization Form completed

☐ Medical Wristband completed

☐ Standardized Procedure started; if yes, name(s) of Standardized Procedure(s) initiated:

DATE RESPONSE SENT TO PATIENT

5/8/07

RN SIGNATURE

G L

DATE RESPONSE SENT TO
PATIENT WITH MD INFORMATION

RN SIGNATURE

Distribution: White-Medical Record

Pink-Inmate (Initial Receipt)

Yellow-Response to Inmate

Goldenrod-MD Response to Patient

FORM 5023 Rev 3/06

SCVMC 6949-6



WHITE CARD / CARTA BLANCA

Housing/Vivienda

4B-1-65

Date/Fecha

5-23-07

Request to see (Circle One):

Medical

Mental Health

Dental

Quiero ver a alguien en (Marque Uno):

Servicios Medicos

Servicios de Salud Mental

Servicios Dental

PFN #

BCJ 774

Booking #/Numero del Registro de Admision

06083690

Name/Nombre

GUTIERREZ

EDWARD

Last Name (Apellido Paterno)

First (Nombre de Pila)

Middle (Segundo Nombre)

Date of Birth/Fecha de Nacimiento

10-23-59

Reason(s) for Request/Razon(es) de esta peticion:

NEED BLOOD TEST FOR
LIVER FUNCTION AND UPDATE ON MY
SURGERY FOR PRE-CANCEROUS GROWTH...

How Long Have You Had This Problem(s)? (Por cuanto tiempo ha tenido usted esta problema(s))

LONG TIME.

NOTE: GIVE THIS FORM ONLY TO A NURSE.

NOTICIA: SOLAMENTE DEBE ENTREGAR ESTE FORMULARIO A UNA ENFERMERA.

DO NOT WRITE BELOW THIS LINE. NO ESCRIBA ABAJO DE ESTA LINA.

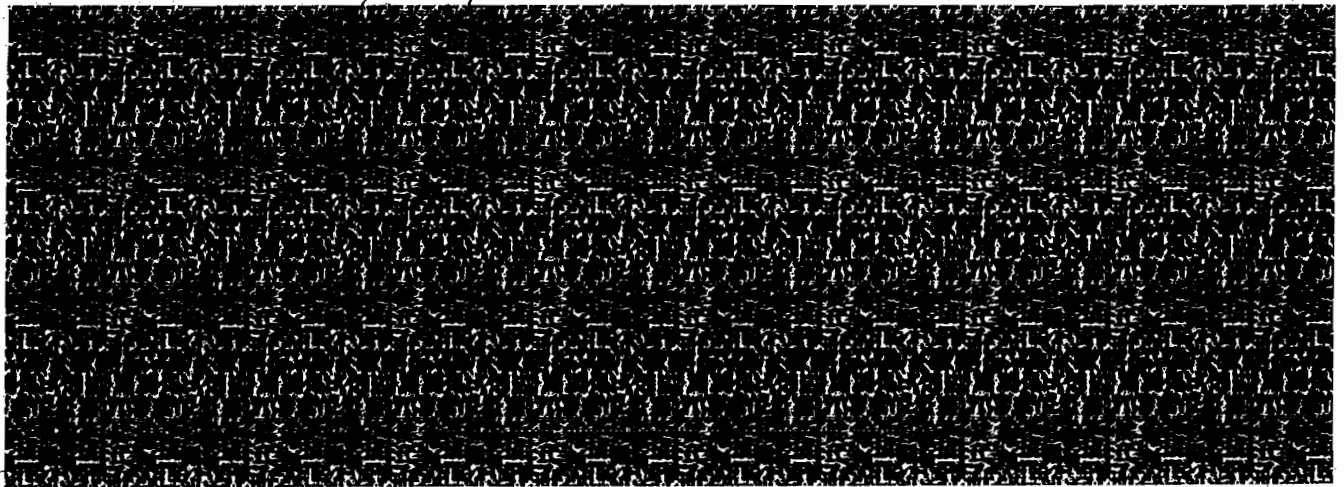
DATE NURSE RECEIVED WHITE CARD FROM PATIENT:

5/24/07

NURSE'S INITIALS:

[Signature]

ASSESSMENT:



☐ The following medication(s) may help you and are available through the Commissary/
La siguiente medicina(s) podria ayudarle y estan disponibles en la Comisaria:

☐ Physician will review your request / El doctor revisara su peticion.

☒ MD Appointment Scheduled / Cita para ver al doctor (week of / la semana de)

☐ Psych MD Appointment Scheduled / Cita para ver al ciciatra (week of / la semana de)

☐ Dental Appointment Scheduled / Cita para ver al dentista (week of / la semana de)

☐ Mental Health will see you / Departamento de Salud Mental te van a ver

☐ No Sleep Medications are given at the Adult Custody Facilities / El la Custodia de Adultos no dan medicina para dormir.

☒ Other Plan of Action / Comments / Otro Plan de Accion

Above MD apt already scheduled
for Edward's request

☐ Patient Health Education Provided Explain:

☐ Medical Authorization Form completed

☐ Medical Wristband completed

☐ Standardized Procedure started; if yes, name(s) of Standardized Procedure(s) initiated:

DATE RESPONSE SENT TO PATIENT 5/24/07 RN SIGNATURE [Signature]

DATE RESPONSE SENT TO
PATIENT WITH MD INFORMATION

RN SIGNATURE



ADULT CUSTODY HEALTH SERVICES
WHITE CARD / CARTA BLANCA

Housing/Vivienda

4B-1-15

Date/Fecha

5-25-07

Request to see (Circle One):

Medical

Mental Health

Dental

Quiero ver a alguien en (Marque Uno):

Servicios Medicos

Servicios de Salud Mental

Servicios Dental

PFN # 86J774

Booking #/Numero del Registro de Admision 06083690

Name/Nombre GUTIERREZ

EDWARD

Last Name (Apellido Paterno)

First (Nombre de Pila)

Middle (Segundo Nombre)

Date of Birth/Fecha de Nacimiento 10-23-59

Reason(s) for Request/Razon(es) de esta peticion: I NEED BLOOD WORK FOR LIVER FUNCTION, AND FOLLOW UP ON SURGERY

How Long Have You Had This Problem(s)? ¿Por cuanto tiempo ha tenido usted esta problema(s)? 10 YRS.

NOTE: GIVE THIS FORM ONLY TO A NURSE.

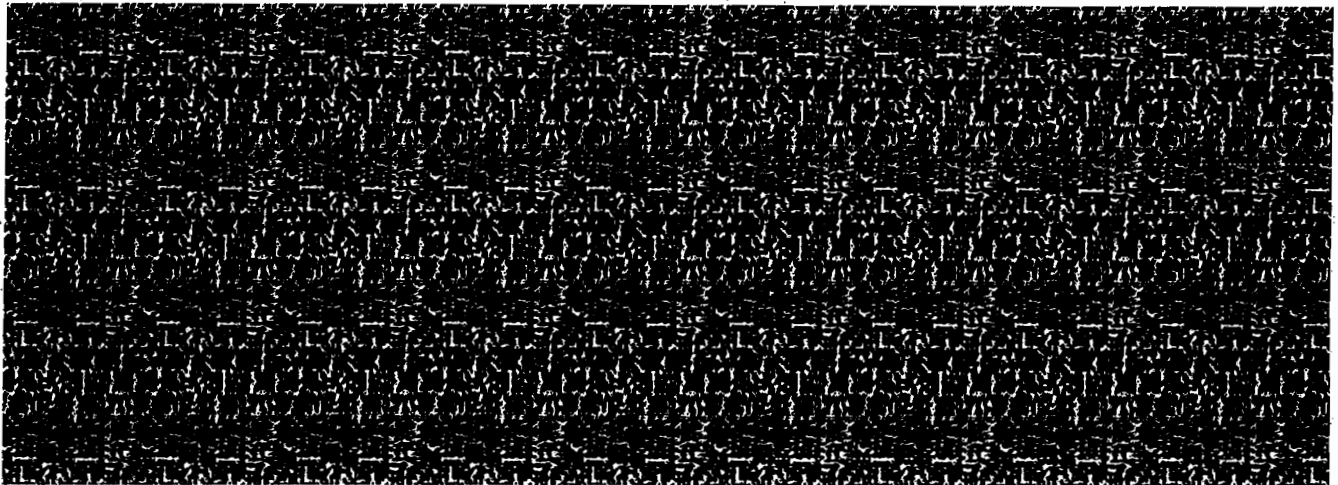
NOTICIA: SOLAMENTE DEBE ENTREGAR ESTE FORMULARIO A UNA ENFERMERA.

DO NOT WRITE BELOW THIS LINE. NO ESCRIBA ABAJO DE ESTA LINA.

DATE NURSE RECEIVED WHITE CARD FROM PATIENT: 5/28/07

NURSE'S INITIALS: JG

ASSESSMENT:



P ☐ The following medication(s) may help you and are available through the Commissary/
La siguiente medicina(s) podria ayudarle y estan disponibles en la Comisaria:

☐ Physician will review your request / El doctor revisara su peticion

☒ MD Appointment Scheduled / Cita para ver al doctor (week of / la semana de) 7/2/07

☐ Psych MD Appointment Scheduled / Cita para ver al ciciatra (week of / la semana de)

☐ Dental Appointment Scheduled / Cita para ver al dentista (week of / la semana de)

☐ Mental Health will see you / Departamento de Salud Mental te van a ver

☐ No Sleep Medications are given at the Adult Custody Facilities / El la Custodia de Adultos no dan medicina para dormir.

☐ Other Plan of Action / Comments / Otro Plan de Accion

☐ Patient Health Education Provided Explain:

☐ Medical Authorization Form completed

☐ Medical Wristband completed

☐ Standardized Procedure started; if yes, name(s) of Standardized Procedure(s) initiated:

DATE RESPONSE SENT TO PATIENT 5/28/07 RN SIGNATURE @ [Signature]

DATE RESPONSE SENT TO
PATIENT WITH MD INFORMATION

RN SIGNATURE



ADULT CUSTODY HEALTH SERVICES
WHITE CARD / CARTA BLANCA

Housing/Vivienda

4B-3-46

Date/Fecha

8-3-07

Request to see (Circle One):

Quiero ver a alguien en (Marque Uno):

Medical

Servicios Medicos

Mental Health

Servicios de Salud Mental

Dental

Servicios Dental

PFN #

BGJ774

Booking #/Numero del Registro de Admision

06083690

Name/Nombre

GUTIERREZ

EDWARD

Last Name (Apellido Paterno)

First (Nombre de Pila)

Middle (Segundo Nombre)

Date of Birth/Fecha de Nacimiento

10-23-59

Reason(s) for Request/Razon(es) de esta peticion:

ON 7-31-07 I WENT TO V.M.C. FOR
AN ULTRA SOUND (WHICH WAS NOT GOOD) I WOULD LIKE TO KNOW
THE DIAGNOSIS AND PLAN OF ACTION???

How Long Have You Had This Problem(s)? ¿Por cuanto tiempo ha tenido usted esta problema(s)?

LONG TIME

NOTE: GIVE THIS FORM ONLY TO A NURSE.

NOTICIA: SOLAMENTE DEBE ENTREGAR ESTE FORMULARIO A UNA ENFERMERA.

DO NOT WRITE BELOW THIS LINE. NO ESCRIBA ABAJO DE ESTA LINA.

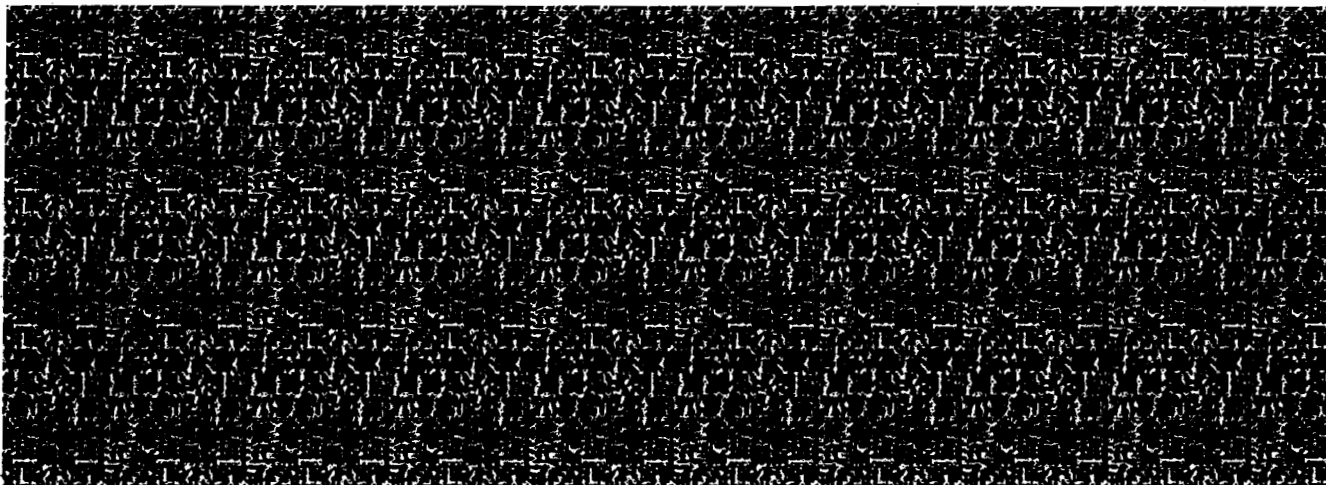
DATE NURSE RECEIVED WHITE CARD FROM PATIENT:

8/7/07

NURSE'S INITIALS:

L

ASSESSMENT:

P ☐ The following medication(s) may help you and are available through the Commissary/

La siguiente medicina(s) podria ayudarle y estan disponibles en la Comisaria:

☐ Physician will review your request / El doctor revisara su peticion☒ MD Appointment Scheduled / Cita para ver al doctor (week of / la semana de)

8/15/07

☐ Psych MD Appointment Scheduled / Cita para ver al ciciatra (week of / la semana de)☐ Dental Appointment Scheduled / Cita para ver al dentista (week of / la semana de)☐ Mental Health will see you / Departamento de Salud Mental te van a ver☐ No Sleep Medications are given at the Adult Custody Facilities / El la Custodia de Adultos no dan medicina para dormir.☒ Other Plan of Action / Comments / Otro Plan de Accion

The doctor will discuss

☐ Patient Health Education Provided Explain:☐ Medical Authorization Form completed☐ Medical Wristband completed☐ Standardized Procedure started; if yes, name(s) of Standardized Procedure(s) initiated:

DATE RESPONSE SENT TO PATIENT

8/7/07

RN SIGNATURE

C dh

DATE RESPONSE SENT TO

PATIENT WITH MD INFORMATION

RN SIGNATURE

Distribution: White-Medical Record

Pink-Inmate (Initial Receipt)

Yellow-Response to Inmate

Goldenrod-MD Response to Patient



Housing/Vivienda

4B-3-46

Date/Fecha 8-3-07

Request to see (Circle One):

Quiero ver a alguien en (Marque Uno):

Medical

Servicios Medicos

Mental Health

Servicios de Salud Mental

Dental

Servicios Dental

PFN # BGJ774

Booking #/Numero del Registro de Admision 06083690

Name/Nombre GUTIERREZ

EDWARD

Last Name (Apellido Paterno)

First (Nombre de Pila)

Middle (Segundo Nombre)

Date of Birth/Fecha de Nacimiento 10-23-59

Reason(s) for Request/Razon(es) de esta peticion: I WOULD LIKE TO FIND OUT THE RESULTS OF BLOOD TEST FOR LIVER-FUNCTION???

How Long Have You Had This Problem(s)? ¿Por cuanto tiempo ha tenido usted esta problema(s)? LONG, LONG TIME

NOTE: GIVE THIS FORM ONLY TO A NURSE.

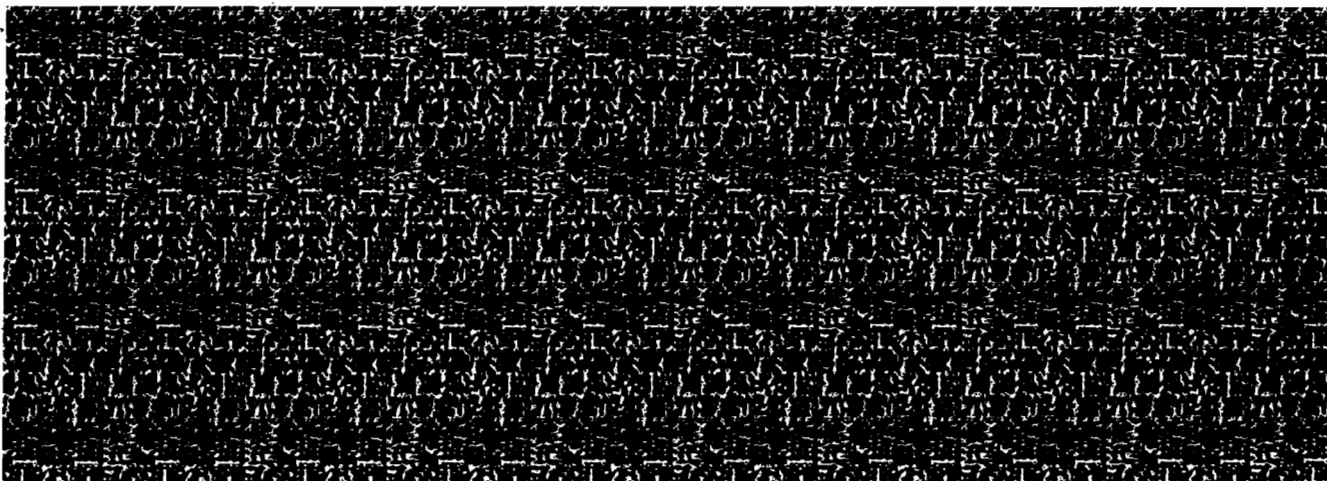
NOTICIA: SOLAMENTE DEBE ENTREGAR ESTE FORMULARIO A UNA ENFERMERA.

DO NOT WRITE BELOW THIS LINE. NO ESCRIBA ABAJO DE ESTA LINA.

DATE NURSE RECEIVED WHITE CARD FROM PATIENT: 8/7/07

NURSE'S INITIALS: [Signature]

ASSESSMENT:



☐ The following medication(s) may help you and are available through the Commissary/
La siguiente medicina(s) podria ayudarle y estan disponibles en la Comisaria:

☐ Physician will review your request / El doctor revisara su peticion

☒ MD Appointment Scheduled / Cita para ver al doctor (week of / la semana de) 8/15/07

☐ Psych MD Appointment Scheduled / Cita para ver al ciciatra (week of / la semana de)

☐ Dental Appointment Scheduled / Cita para ver al dentista (week of / la semana de)

☐ Mental Health will see you / Departamento de Salud Mental te van a ver

☐ No Sleep Medications are given at the Adult Custody Facilities / El la Custodia de Adultos no dan medicina para dormir.

☒ Other Plan of Action / Comments / Otro Plan de Accion Talk to me. He will discuss the result.

☐ Patient Health Education Provided Explain:

☐ Medical Authorization Form completed

☐ Medical Wristband completed

☐ Standardized Procedure started; if yes, name(s) of Standardized Procedure(s) initiated:

DATE RESPONSE SENT TO PATIENT 8/7/07

RN SIGNATURE [Signature]

DATE RESPONSE SENT TO
PATIENT WITH MD INFORMATION

RN SIGNATURE

Distribution: White-Medical Record

Pink-Inmate (Initial Receipt)

Yellow-Response to Inmate

Goldenrod-MD Response to Patient

SAN JUAN COUNTY CORRECTION DEPARTMENT

INMATE NO.	INMATE NAME	INMATE NO.	INMATE NAME
INMATE NO.	INMATE NAME	INMATE NO.	INMATE NAME

DO NOT EAT ANY TURKEY (EVERY YEAR) I HAVE PUT IN REQUEST FORMS, I'VE HAD 3/4'S CALL KITCHEN AND NO RESULTS... I AM SUPPOSED TO HAVE A "NO TURKEY" DIET I HAVE ALL READY BEEN TESTED FOR TURKEY ALLERGY.

WHAT SOLUTION ARE YOU RECOMMENDING? **NO TURKEY, NO EGGS DIET**

Your Signature: [Signature] Date: 11/30/07 Time: 500 AM ☒ AM ☐ PM
(Do not write below this line. Use additional sheets if necessary)

Received from Inmate on: _____
Day: Friday Date: 11/30/07 Time: 1620 Officer: MORA Team: B

RESPONDING OFFICER'S STATEMENT (Please print): _____

☒ Resolved ☒ Refer to Level II

Officer's Name: _____ Team: _____ Date: _____/_____/_____
SUPERVISOR'S ACTION: _____

☐ Resolved ☐ Refer to Level III

Supervisor's Name: _____ Team: _____ Date: _____/_____/_____
SHIFT LIEUTENANT REVIEW: ☐ Concur ☐ Reversed

SIGNATURE: _____ Date: _____/_____/_____ Time: _____

REPORT REVIEW RESPONSE: Unit Assigned: _____ Date Assigned: _____/_____/_____
Date Due: _____/_____/_____

SIGNATURE: _____ Date: _____/_____/_____ Time: _____

RESPONSE RETURNED TO INMATE: Date: _____/_____/_____ Time: _____ By: _____
Distribution: White-Administration ☐ Canary-Inmate (Final Disposition) ☐ Pink-Inmate (Initial Receipt) ☐

ADULT CUSTODY HEALTH SERVICES
WHITE CARD REQUEST FORM

First Name (Apellido Paterno) SUTTER, 2 First (Nombre de Pila) EDWARD Middle (Segundo Nombre)

Reason(s) for Request/Reason(s) de esta petición I NEED AN ORDER 10-27-59
SPECIAL DIET SENT TO DIETITIAN, ALL READY TESTED.

How Long Have You Had This Problem(s)? Por cuanto tiempo ha tenido usted esta problem(s)? NO TURKEY, NO EGGS
DIET ORDER

NOTE: GIVE THIS FORM ONLY TO A NURSE.
NOTICIA: SOLAMENTE DEBE ENTREGAR ESTE FORMULARIO A UNA ENFERMERA
DO NOT WRITE BELOW THIS LINE. NO ESCRIBA ABAJO DE ESTA LINEA

DATE NURSE RECEIVED WHITE CARD FROM PATIENT: 12/13 NURSE'S INITIALS Kenney

ASSESSMENT

[REDACTED]

The following medication(s) may help you and are available through the Commissary/
La siguiente medicina(s) podría ayudarle y están disponibles en la Comisaria:

- ☐ Physician will review your request / El doctor revisara su petición
- ☐ MD Appointment Scheduled / Cita para ver al doctor (week of / la semana de)
- ☐ Psych MD Appointment Scheduled / Cita para ver al psiquiatra (week of / la semana de)
- ☐ Dental Appointment Scheduled / Cita para ver al dentista (week of / la semana de)
- ☐ Mental Health will see you / Departamento de Salud Mental te van a ver
- ☐ No Sleep Medications are given at the Adult Custody Facilities / En la Custodia de Adultos no dan medicina para dormir
- ☐ Other Plan of Action / Comments / Otro Plan de Acción

Result Shows not allergic to turkey / meat

☐ Patient Health Education Provided Explain

☐ Medical Authorization Form completed ☐ Medical Writup completed

Standardized procedure started if yes, name(s) of Standardized Procedure(s) initiated on

DATE RESPONSE SENT TO PATIENT 12/13 RN SIGNATURE Kenney

DATE RESPONSE SENT TO PATIENT WITH MD INFORMATION RN SIGNATURE

Distribution: White-Medical Record Pink-Inmate (Initial Receipt) Yellow-Response to Inmate Goldenrod-MD Response to Patient

OPTIONAL FORM 100-100-100



ADULT CUSTODY HEALTH SERVICES
WHITE CARD / CARTA BLANCA

Housing/Vivienda

Date/Fecha

Request to see (Circle One):

Quiero ver a alguien en (Marque Uno):

Medical
Servicios Medicos

Mental Health
Servicios de Salud Mental

Dental
Servicios Dental

PFN #

BGJ774

Booking #/Numero del Registro de Admision

06083690

Name/Nombre

GUTIERREZ

EDWARD

Last Name (Apellido Paterno)

First (Nombre de Pila)

Middle (Segundo Nombre)

Date of Birth/Fecha de Nacimiento

10-23-59

Reason(s) for Request/Razon(es) de esta peticion:

NEED BENCDRYL + TYLENOL; SEVER
ALLERGIES + ALLERGY INDUCED ASTHMA.

How Long Have You Had This Problem(s)? ¿Por cuanto tiempo ha tenido usted esta problema(s)?

NOTE: GIVE THIS FORM ONLY TO A NURSE.

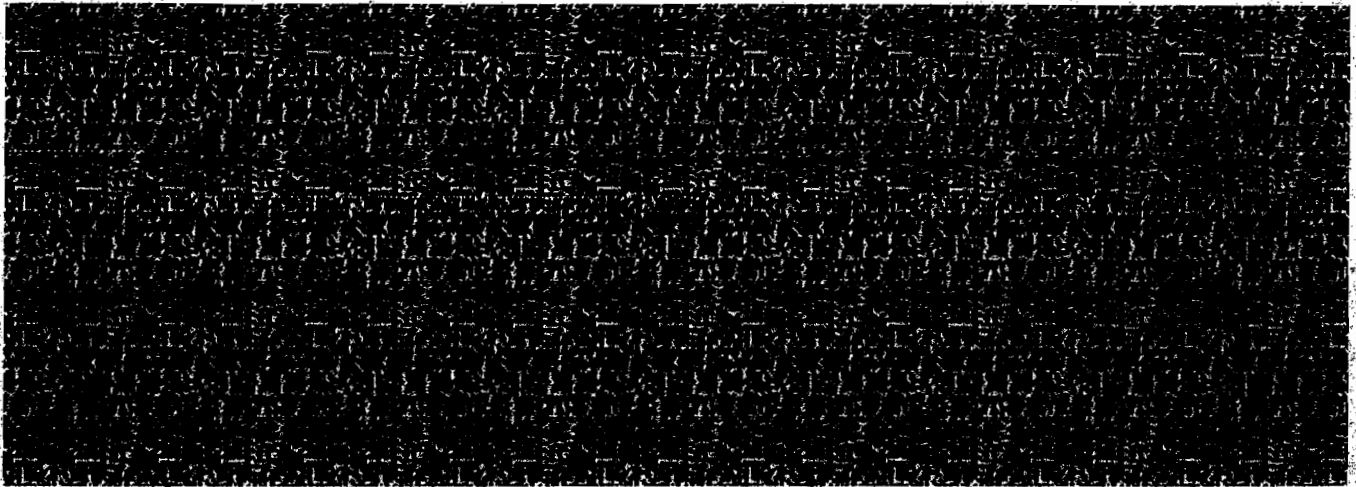
NOTICIA: SOLAMENTE DEBE ENTREGAR ESTE FORMULARIO A UNA ENFERMERA.

DO NOT WRITE BELOW THIS LINE. NO ESCRIBA ABAJO DE ESTA LINA.

DATE NURSE RECEIVED WHITE CARD FROM PATIENT:

NURSE'S INITIALS:

ASSESSMENT:



P ☐ The following medication(s) may help you and are available through the Commissary/
La siguiente medicina(s) podria ayudarle y estan disponibles en la Comisaria:

☐ Physician will review your request / El doctor revisara su peticion

☐ MD Appointment Scheduled / Cita para ver al doctor (week of / la semana de)

☐ Psych MD Appointment Scheduled / Cita para ver al ciciatra (week of / la semana de)

☐ Dental Appointment Scheduled / Cita para ver al dentista (week of / la semana de)

☐ Mental Health will see you / Departamento de Salud Mental te van a ver

☐ No Sleep Medications are given at the Adult Custody Facilities / El la Custodia de Adultos no dan medicina para dormir.

☐ Other Plan of Action / Comments / Otro Plan de Accion

☐ Patient Health Education Provided Explain:

☐ Medical Authorization Form completed

☐ Medical Wristband completed

☒ Standardized Procedure started; if yes, name(s) of Standardized Procedure(s) initiated:

DATE RESPONSE SENT TO PATIENT

RN SIGNATURE

DATE RESPONSE SENT TO

PATIENT WITH MD INFORMATION

RN SIGNATURE

Distribution: White-Medical Record

Pink-Inmate (Initial Receipt)

Yellow-Response to Inmate

Goldenrod-MD Response to Patient



ADULT CUSTODY HEALTH SERVICES
WHITE CARD / CARTA BLANCA

Housing/Vivienda

4B 1 15

Date/Fecha

3-1-07

Request to see (Circle One):

Quiero ver a alguien en (Marque Uno):

Medical
Servicios Medicos

Mental Health
Servicios de Salud Mental

Dental
Servicios Dental

PFN #

06083690 / BGJ774

Booking #/Numero del Registro de Admision

06083690

Name/Nombre

GUTIERREZ

EDWARD

Last Name (Apellido Paterno)

First (Nombre de Pila)

Middle (Segundo Nombre)

Date of Birth/Fecha de Nacimiento

10-23-59

Reason(s) for Request/Razon(es) de esta peticion:

NEED BLUE BRYL FOR SEVER
ALLERGIES, & ANSWER ON MY LAST WHITE CARD?

How Long Have You Had This Problem(s)? ¿Por cuanto tiempo ha tenido usted esta problema(s)?

NOTE: GIVE THIS FORM ONLY TO A NURSE.

NOTICIA: SOLAMENTE DEBE ENTREGAR ESTE FORMULARIO A UNA ENFERMERA.

DO NOT WRITE BELOW THIS LINE. NO ESCRIBA ABAJO DE ESTA LINA.

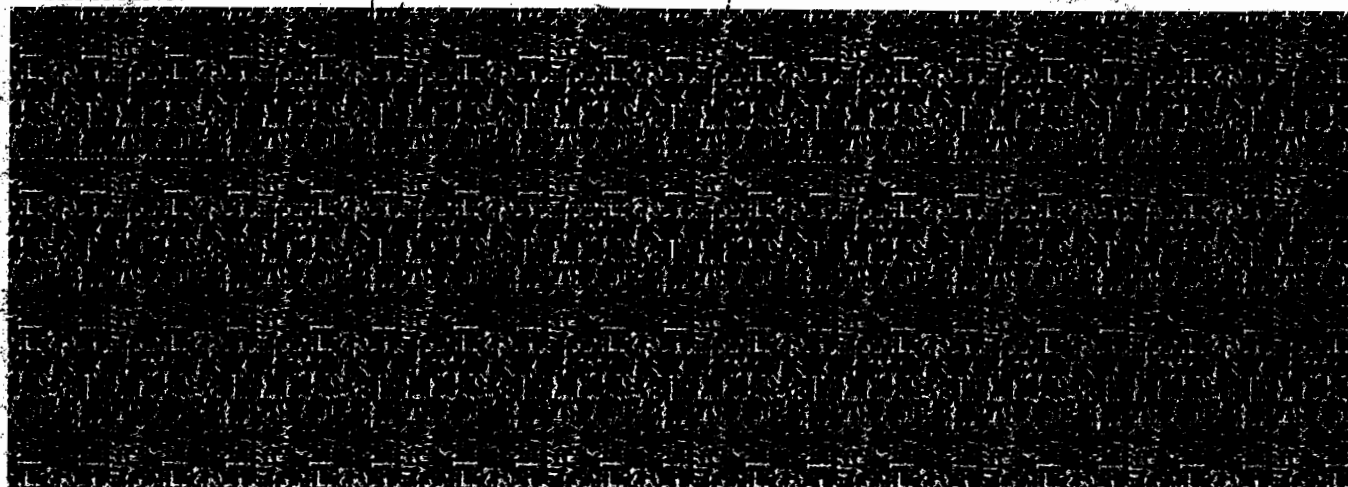
DATE NURSE RECEIVED WHITE CARD FROM PATIENT:

3/1/07

NURSE'S INITIALS:

ln

ASSESSMENT:



☐ The following medication(s) may help you and are available through the Commissary/
La siguiente medicina(s) podria ayudarle y estan disponibles en la Comisaria:

☒ Physician will review your request / El doctor revisara su peticion

☐ MD Appointment Scheduled / Cita para ver al doctor (week of / la semana de)

☐ Psych MD Appointment Scheduled / Cita para ver al ciciatra (week of / la semana de)

☐ Dental Appointment Scheduled / Cita para ver al dentista (week of / la semana de)

☐ Mental Health will see you / Departamento de Salud Mental te van a ver

☐ No Sleep Medications are given at the Adult Custody Facilities / El la Custodia de Adultos no dan medicina para dormir.

☐ Other Plan of Action / Comments / Otro Plan de Accion

lnclante

☐ Patient Health Education Provided Explain:

☐ Medical Authorization Form completed

☐ Medical Wristband completed

☐ Standardized Procedure started; if yes, name(s) of Standardized Procedure(s) initiated:

DATE RESPONSE SENT TO PATIENT

8 3/1/07

RN SIGNATURE

ln

DATE RESPONSE SENT TO

PATIENT WITH MD INFORMATION

RN SIGNATURE

Distribution: White-Medical Record

Pink-Inmate (Initial Receipt)

Yellow-Response to Inmate

Goldenrod-MD Response to Patient

SANTA CLARA VALLEY HEALTH AND HOSPITAL SYSTEM
ADULT CUSTODY HEALTH SERVICES
WHITE CARD / CARTA BLANCAHousing/Vivienda 4B-1-15Date/Fecha 5-22-07

Request to see (Circle One):

Quiero ver a alguien en (Marque Uno):

☒ Medical
Servicios Medicos☐ Mental Health
Servicios de Salud Mental☐ Dental
Servicios DentalPFN # UGJ 774Booking #/Numero del Registro de Admision 06083690

Name/Nombre

Last Name (Apellido Paterno) GUTIERREZFirst (Nombre de Pila) EDWARD

Middle (Segundo Nombre)

Date of Birth/Fecha de Nacimiento 10 23 59

Reason(s) for Request/Razon(es) de esta peticion:

I NEED BENEDRYL
SEVER ALLERGIES.How Long Have You Had This Problem(s)? ¿Por cuanto tiempo ha tenido usted esta problema(s)? 20 YEARS

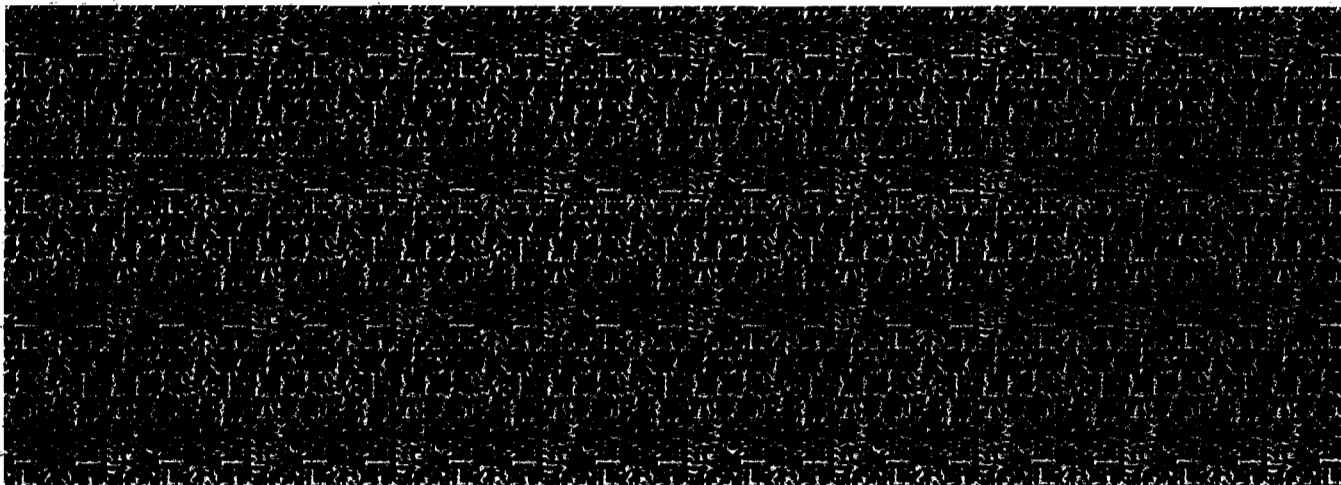
NOTE: GIVE THIS FORM ONLY TO A NURSE.

NOTICIA: SOLAMENTE DEBE ENTREGAR ESTE FORMULARIO A UNA ENFERMERA.

DO NOT WRITE BELOW THIS LINE. NO ESCRIBA ABAJO DE ESTA LINA.

DATE NURSE RECEIVED WHITE CARD FROM PATIENT: 5/22/07NURSE'S INITIALS: JS

ASSESSMENT:

P ☒ The following medication(s) may help you and are available through the Commissary/

La siguiente medicina(s) podria ayudarle y estan disponibles en la Comisaria:

Benedryl

- ☐ Physician will review your request / El doctor revisara su peticion
- ☐ MD Appointment Scheduled / Cita para ver al doctor (week of / la semana de)
- ☐ Psych MD Appointment Scheduled / Cita para ver al ciciatra (week of / la semana de)
- ☒ Dental Appointment Scheduled / Cita para ver al dentista (week of / la semana de) 6-18-07
- ☒ Mental Health will see you / Departamento de Salud Mental te van a ver 7-16-07
- ☐ No Sleep Medications are given at the Adult Custody Facilities / El la Custodia de Adultos no dan medicina para dormir.
- ☐ Other Plan of Action / Comments / Otro Plan de Accion

☐ Patient Health Education Provided Explain:☐ Medical Authorization Form completed☐ Medical Wristband completed☐ Standardized Procedure started; if yes, name(s) of Standardized Procedure(s) initiated:DATE RESPONSE SENT TO PATIENT 5/27/07 RN SIGNATURE PJ

DATE RESPONSE SENT TO

PATIENT WITH MD INFORMATION

RN SIGNATURE

Distribution: White-Medical Record

Pink-Inmate (Initial Receipt)

Yellow-Response to Inmate

Goldenrod-MD Response to Patient

Housing/Vivienda

4B-1-15

Date/Fecha

5-24-07

Request to see (Circle One):

Quiero ver a alguien en (Marque Uno):

Medical

Servicios Medicos

Mental Health

Servicios de Salud Mental

Dental

Servicios Dental

PFN # 865774

Booking #/Numero del Registro de Admision

06083690

Name/Nombre

GUTIERREZ

EDWARD

Last Name (Apellido Paterno)

First (Nombre de Pila)

Middle (Segundo Nombre)

Date of Birth/Fecha de Nacimiento

10-23-59

Reason(s) for Request/Razon(es) de esta peticion:

I CANNOT TAKE STORE BOUGHT
ANTIHISTAMINE, THE DOCTOR KNOWS THIS. NEED
BENEDRYL

How Long Have You Had This Problem(s)? ¿Por cuanto tiempo ha tenido usted esta problema(s)?

20 YRS.

NOTE: GIVE THIS FORM ONLY TO A NURSE.

NOTICIA: SOLAMENTE DEBE ENTREGAR ESTE FORMULARIO A UNA ENFERMERA.

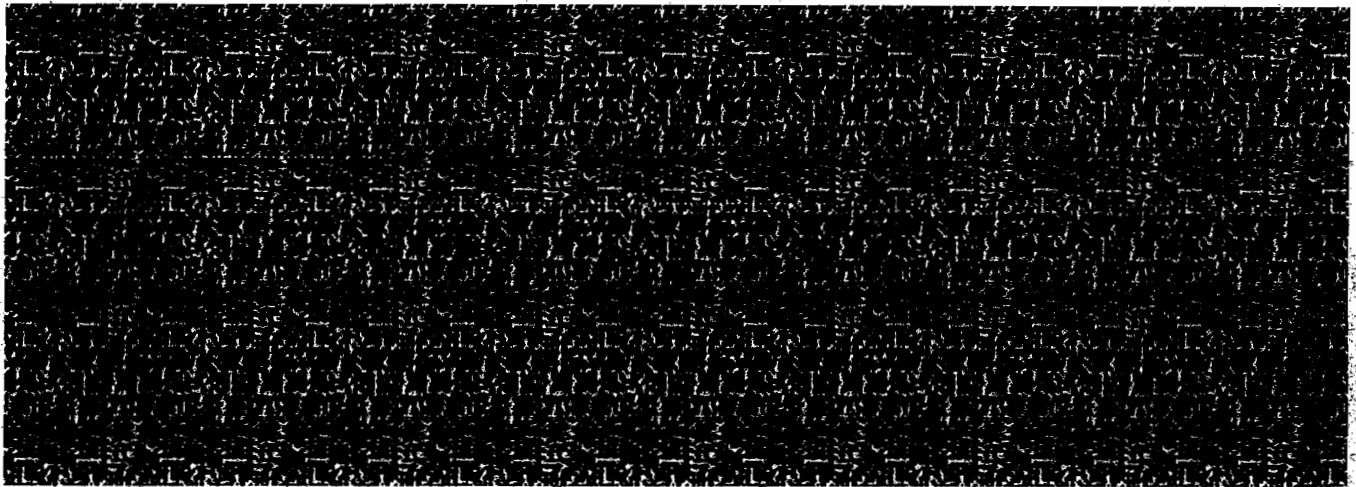
DO NOT WRITE BELOW THIS LINE. NO ESCRIBA ABAJO DE ESTA LINA.

DATE NURSE RECEIVED WHITE CARD FROM PATIENT:

5/28/07

NURSE'S INITIALS: d

ASSESSMENT:



P ☐ The following medication(s) may help you and are available through the Commissary/

La siguiente medicina(s) podria ayudarle y estan disponibles en la Comisaria:

☐ Physician will review your request / El doctor revisara su peticion

☒ MD Appointment Scheduled / Cita para ver al doctor (week of / la semana de) 7/24/07

☐ Psych MD Appointment Scheduled / Cita para ver al ciciatra (week of / la semana de)

☐ Dental Appointment Scheduled / Cita para ver al dentista (week of / la semana de)

☐ Mental Health will see you / Departamento de Salud Mental te van a ver

☐ No Sleep Medications are given at the Adult Custody Facilities / El la Custodia de Adultos no dan medicina para dormir.

☐ Other Plan of Action / Comments / Otro Plan de Accion

☐ Patient Health Education Provided Explain:

☐ Medical Authorization Form completed

☐ Medical Wristband completed

☐ Standardized Procedure started; if yes, name(s) of Standardized Procedure(s) initiated:

DATE RESPONSE SENT TO PATIENT

5/28/07

RN SIGNATURE

[Signature]

DATE RESPONSE SENT TO

PATIENT WITH MD INFORMATION

RN SIGNATURE



SANTA CLARA VALLEY HEALTH AND HOSPITAL SYSTEM
ADULT CUSTODY HEALTH SERVICES
WHITE CARD / CARTA BLANCA

REQUEST # TWO.

Housing/Vivienda

48-3-46

Date/Fecha

8-23-07

Request to see (Circle One):

Medical

Mental Health

Dental

Quiero ver a alguien en: (Marque Uno):

Servicios Medicos

Servicios de Salud Mental

Servicios Dental

PFN # 06083690 B6774

Booking #/Numero del Registro de Admision

06083690

Name/Nombre

GUTIERREZ

EDWARD

Last Name (Apellido Paterno)

First (Nombre de Pila)

Middle (Segundo Nombre)

Date of Birth/Fecha de Nacimiento

10-23-59

Reason(s) for Request/Razon(es) de esta peticion:

ON 8-13-07 THE DOCTOR TOLD ME HE WOULD
PRESCRIBE BENEDRYL FOR TWO WEEKS... I HAVE NOT RECEIVED THIS RX.
I HAVE TWO BOTTLES OF CANTEEN ANTIHISTAMINE IT DOES NOT WORK

How Long Have You Had This Problem(s)? ¿Por cuanto tiempo ha tenido usted esta problema(s)?

VERY LONG TIME

NOTE: GIVE THIS FORM ONLY TO A NURSE.

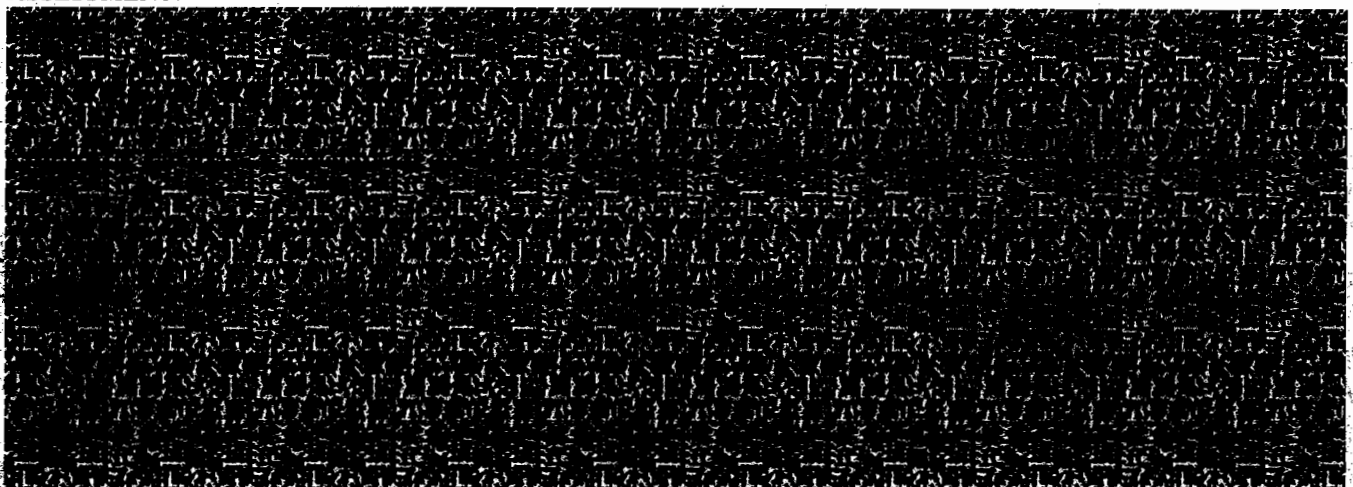
NOTICIA: SOLAMENTE DEBE ENTREGAR ESTE FORMULARIO A UNA ENFERMERA.

DO NOT WRITE BELOW THIS LINE. NO ESCRIBA ABAJO DE ESTA LINA.

DATE NURSE RECEIVED WHITE CARD FROM PATIENT:

NURSE'S INITIALS:

ASSESSMENT:



☐ The following medication(s) may help you and are available through the Commissary/

La siguiente medicina(s) podria ayudarle y estan disponibles en la Comisaria:

☒ Physician will review your request / El doctor revisara su peticion

☐ MD Appointment Scheduled / Cita para ver al doctor (week of / la semana de)

☐ Psych MD Appointment Scheduled / Cita para ver al ciciatra (week of / la semana de)

☐ Dental Appointment Scheduled / Cita para ver al dentista (week of / la semana de)

☐ Mental Health will see you / Departamento de Salud Mental te van a ver

☐ No Sleep Medications are given at the Adult Custody Facilities / El la Custodia de Adultos no dan medicina para dormir.

☒ Other Plan of Action / Comments / Otro Plan de Accion

no benadryl ordered

☐ Patient Health Education Provided Explain:

☐ Medical Authorization Form completed

☐ Medical Wristband completed

☐ Standardized Procedure started; if yes, name(s) of Standardized Procedure(s) initiated:

DATE RESPONSE SENT TO PATIENT

8/23/07

RN SIGNATURE

[Signature]

DATE RESPONSE SENT TO
PATIENT WITH MD INFORMATION

RN SIGNATURE

Distribution: White-Medical Record

Pink-Inmate (Initial Receipt)

Yellow-Response to Inmate

Goldenrod-MD Response to Patient

EXHIBIT 2

[illegible]

13
14
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27
28

STARTED ASKING IN DECEMBER
RECEIVED INFO. 2 MONTHS
LATER. 2. M.

SANTA CLARA COUNTY HEALTH CARE SERVICES

Civil Complaint

Case No. 10-23-51

Plaintiff: [Redacted]

Defendant: [Redacted]

Request for Discovery (Interrogatories) de esta petición: I NEED THE NAME OF THE LAST DOCTOR
TO SEE ME OLDER WHITE MALE WITH STROKE ALSO NEED NAME OF
NURSE AND ALSO NURSE FOR LEGAL REASONS

NOTE: GIVE THIS FORM ONLY TO A NURSE

ENFERMERA: SOLAMENTE DEBE ENTREGAR ESTE FORMULARIO A UNA ENFERMERA

DO NOT WRITE BELOW THIS LINE NO ESCRIBA ABAJO DE ESTA LINEA

DATE NURSE RECEIVED WHITE CARD FROM PATIENT _____ NURSE'S INITIALS _____

INMATE REQUEST FORM

INMATE NAME: E. GUTIERREZ DATE 1-3-08
 CEN: 06083690 PFN: BGJ774 HOUSING UNIT: 4B-3-34

1. CONTACT REQUEST: OUTSIDE AGENCY

☐ DISTRICT ATTORNEY ☐ PUBLIC DEFENDER ☐ ADULT PROBATION ☐ STATE PAROLE ☐ OTHER SPECIFY: _____

NATURE OF REQUEST: _____

RECEIVED

2. CONTACT/INFORMATION: INSIDE FACILITY

FEB 08 2008

CLASSIFICATION SECTION	INMATE SERVICE DIRECTOR	PROGRAMS DIRECTOR	ADMINISTRATIVE BOOKING	MAIN JAIL MEDICAL OTHER
<input type="checkbox"/> REHOUSING	<input type="checkbox"/> COMMISSARY	<input type="checkbox"/> LAW LIBRARY	<input type="checkbox"/> RELEASE DATE	<input type="checkbox"/> CHAPLAIN
<input type="checkbox"/> TRUSTEE	<input type="checkbox"/> MONEY ACCOUNT	<input type="checkbox"/> A.A.	<input type="checkbox"/> CHARGES	<input type="checkbox"/> FOOD SERVICE
<input type="checkbox"/> RECLASS.	<input type="checkbox"/> MAIL	<input type="checkbox"/> FRIENDS OUTSIDE	<input type="checkbox"/> BAIL	<input type="checkbox"/> BAIL BONDS
<input type="checkbox"/> WWP	<input type="checkbox"/> LOST PROPERTY	<input type="checkbox"/> OTHER: SPECIFY BELOW	<input type="checkbox"/> NEXT COURT DATE	<input checked="" type="checkbox"/> OTHER: SPECIFY BELOW
<input type="checkbox"/> PSP	<input type="checkbox"/> LOST CLOTHING			

NATURE OF REQUEST: I NEED CHIEF DOCTOR'S AND HEAD NURSES NAMES? ALSO NAMES OF ALL DOCTORS I SAW IN THE LAST YEAR HERE IN D.O.C.

3. ACTION TAKEN/RESPONSE

☐ RESPONSE BELOW ☐ REQUEST FORWARDED OUTSIDE FACILITY ☐ REQUEST DENIED SEE EXPLANATION ☐ CANNOT BE ACTED ON AT THIS TIME.

☐ PREVIOUS REQUEST IN PROGRESS

EXPLANATION/RESPONSE: _____

Per your request I am sending the information to you today.

OFFICER

SIGNATURE: Carmen Gonzalez H.I.T.

BADGE # H.I.T.

DATE 02-08-08

TIME 3:05 P.M.

INMATE'S NAME: <u>EDWARD GUTIERREZ</u>	BOOKING NUMBER: <u>06083690</u>	HOUSING UNIT: <u>4B 3 34</u>
--	---------------------------------	------------------------------

DETAILS OF GRIEVANCE. PRINT! BE SPECIFIC! I NEED THE FOLLOWING NAMES FOR FEDERAL RECOURSE: HEAD DOCTOR OF D.O.C. HEAD-NURSE OF D.O.C. NAMES OF ALL DOCTOR TREATING EDWARD GUTIERREZ IN THE PAST 12 MONTHS.
THERE IS A COURT DEAD-LINE FOR THIS INFO. PLEASE RESPOND???

WHAT SOLUTION ARE YOU RECOMMENDING?: PLEASE SEND THE ABOVE NAMES?
Your Signature: [Signature] Date: 1/10/08 Time: 9:00 AM PM
(Do NOT write below this line. Use additional sheets if necessary)

Received from Inmate on:
Day: FRIDAY Date: 1/11/08 Time: 1140 Officer: WARTZ 12 #2647 Team: B

RESPONDING OFFICER'S STATEMENT (Please print):
20:58 000222 NUT

[] Resolved [X] Refer to Level II
Officer's Name: _____ Team: _____ Date: ____/____/____

SUPERVISOR'S ACTION: _____

RECEIVED

FEB 08 2008

[] Resolved [] Refer to Level III
Supervisor's Name: _____ Team: _____ Date: ____/____/____

SHIFT LIEUTENANT REVIEW: [] Concur [] Reversed _____

SIGNATURE: _____ Date: ____/____/____ Time: ____:____:____

SUPPORT SERVICE RESPONSE: Unit Assigned: Medical Date Assigned: ____/____/____
Date Due: 01/17/08

Response by: _____ Title: _____ Date: ____/____/____ Time: ____:____:____

FACILITY COMMANDER/DESIGNEE REVIEW: [] Concur [] Reversed _____

Information has been sent to you on 2-08-08
SIGNATURE: Lermen Gonzalez H.T. Date: 02/08/08 Time: 3:04 P.M.

RESPONSE RETURNED TO INMATE: Date: ____/____/____ Time: ____:____:____ By: _____
Distribution: White-Administration Canary-Inmate (Final Disposition) Pink-Inmate (Initial Receipt)

*Dedicated to the Health
of the Whole Community*

February 8th 2008



Adult Custody Mental Health Services

Main Jail
150 West Hedding Street
San Jose, California 95110
Tel. (408) 808-5200
Fax. (408) 808-5236

Elmwood
701 S. Abel Street
Milpitas, California 95035
Tel (408) 957-5360
Fax (408) 946-8023

**Mr. Edward Gutierrez,
PFN. BGJ774 HOUSING 4-C-3**

Re: GUTIERREZ, EDWARD. D.O.B. 10-23-59

To Whom It May Concern:

Receipt of request for medical information on the above patient is acknowledged.

Any items checked below are applicable to this request.

____ Enclosed is all the medical information, which by law is permitted to be disclosed. The report is Strictly Confidential and is for the information only of the person to whom it is addressed, It is unlawful to give information to any other party.

____ We are unable to identify this individual. Please provide additional information; i.e. date of birth, social security number, PFN, treatment date, verification of spelling of name or other names patient may have used.

____ Records have been purged.... Unable to locate records.

____ The information your have requested was previously mailed on:

____ Make check payable to Santa Clara Valley Health and Hospital System for the amount:

X Other: **In response to your request for information.**

Head of Medical Department: Dr. Alexander Chyorny,
Head Nurse: Lori Horn, R.N. Nurse Manager,
Doctors in the last 12 months: Dr. Maria Juarez-Reyes, —
Dr. John C. Lukrich, —
Dr. G. Versales, —
Dr. Anita Gaddipati, —
Diane Garcia, R.N.P.

Sincerely:

Carmen Gonzalez
MEDICAL RECORDS DEPARTMENT
CARMEN GONZALEZ,
HEALTH INFORMATION TECH.

INMATE REQUEST FORM

INMATE NAME: EDWARD GUTIERREZ DATE 12-28-07
 CEN: 06083690 PFN: BGJ774 HOUSING UNIT: 4B 3 34

1. CONTACT REQUEST: OUTSIDE AGENCY

☐ DISTRICT ATTORNEY ☐ PUBLIC DEFENDER ☐ ADULT PROBATION ☐ STATE PAROLE ☐ OTHER SPECIFY: _____

NATURE OF REQUEST: _____

2. CONTACT/INFORMATION: INSIDE FACILITY

CLASSIFICATION SECTION	INMATE SERVICE DIRECTOR	PROGRAMS DIRECTOR	ADMINISTRATIVE BOOKING	OTHER
<input type="checkbox"/> REHOUSING	<input type="checkbox"/> COMMISSARY	<input type="checkbox"/> LAW LIBRARY	<input type="checkbox"/> RELEASE DATE	<input type="checkbox"/> CHAPLAIN
<input type="checkbox"/> TRUSTEE	<input type="checkbox"/> MONEY ACCOUNT	<input type="checkbox"/> A.A.	<input type="checkbox"/> CHARGES	<input type="checkbox"/> FOOD SERVICE
<input type="checkbox"/> RECLASS.	<input type="checkbox"/> MAIL	<input type="checkbox"/> FRIENDS OUTSIDE	<input type="checkbox"/> BAIL	<input type="checkbox"/> BAIL BONDS
<input type="checkbox"/> WWP	<input type="checkbox"/> LOST PROPERTY	<input type="checkbox"/> OTHER: SPECIFY BELOW	<input type="checkbox"/> NEXT COURT DATE	<input checked="" type="checkbox"/> OTHER: SPECIFY BELOW
<input type="checkbox"/> PSP	<input type="checkbox"/> LOST CLOTHING			

NATURE OF REQUEST: I NEED THE NAMES OF THE DIRECTOR OF CORRECTIONS AND FACILITY COMANDER FOR LEGAL "PENDING" LITIGATION DEAD-LINE OF 1-12-08 THANK YOU.

3. ACTION TAKEN/RESPONSE

☒ RESPONSE BELOW ☐ REQUEST FORWARDED OUTSIDE FACILITY ☐ REQUEST DENIED SEE EXPLANATION ☐ CANNOT BE ACTED ON AT THIS TIME.
☐ PREVIOUS REQUEST IN PROGRESS

EXPLANATION/RESPONSE: INMATE ORIENTATION AND RULE BOOK

PROVIDED WITH WITH REQUESTED INFORMATION
NO SUCH INFORMATION IN RULE BOOK. SK

OFFICER SIGNATURE: REYES

BADGE # 2515 DATE 12/28/07 TIME 0500

INMATE REQUEST FORM

U.S. DIST. JUDGE MAXINE M. CHESNEY.

INMATE NAME: EDWARD GUTIERREZ

DATE 12-18-07

CEN: 06083690

RFN: BGJ774

HOUSING UNIT: 4B-3-34

1. CONTACT REQUEST: OUTSIDE AGENCY

☐DISTRICT
ATTORNEY☐PUBLIC
DEFENDER☐ADULT
PROBATION☐STATE
PAROLE☐OTHER
SPECIFY: _____

NATURE OF REQUEST _____

2. CONTACT/INFORMATION: INSIDE FACILITY

CLASSIFICATION
SECTIONINMATE SERVICE
DIRECTORPROGRAMS
DIRECTORADMINISTRATIVE
BOOKING

OTHER

☐

REHOUSING

☐

COMMISSARY

☐LAW
LIBRARY☐RELEASE
DATE☐

CHAPLAIN

☐

TRUSTEE

☐

MONEY ACCOUNT

☐

A.A.

☐

CHARGES

☐

FOOD SERVICE

☐

RECLASS.

☐

MAIL

☐FRIENDS
OUTSIDE☐

BAIL

☐

BAIL BONDS

☐

WWP

☐

LOST PROPERTY

☐OTHER:
SPECIFY
BELOW☐NEXT COURT
DATE☒OTHER:
SPECIFY BELOW☐

PSP

☐

LOST CLOTHING

NATURE OF REQUEST:

CAPTAIN D. SEPULVEDA YOU HAVE REQUESTED THAT
I FORWARD COURT ORDER AND PROOF OF SERVICE
TO DEPARTMENT. ALTHOUGH I DO HAVE SAID DOCUMENTS IN MY
CELL I DO NOT WANT THEM TO GET MISPLACED, AS I ONLY
HAVE ONE COPY... PLEASE SEND PROPER COORDINATOR TO PICK THEM
UP. I HAVE A DEADLINE TO RESPOND TO COURT...

3. ACTION TAKEN/RESPONSE

☐RESPONSE
BELOW☐REQUEST FORWARDED
OUTSIDE FACILITY☐REQUEST DENIED
SEE EXPLANATION☐CANNOT BE ACTED
ON AT THIS TIME.☐

PREVIOUS REQUEST IN PROGRESS

EXPLANATION/RESPONSE:

picked up 12/19/07

[Signature]

SIGNATURE

BADGE #

DATE

TIME

ORIGINAL-RECORD FILE

CANARY-RETURN TO INMATE AFTER ACTION

PINK-RETURNED TO INMATE

806.00

INMATE REQUEST FORM

39

INMATE NAME: EDWARD GUTIERREZDATE 1-16-08CEN: 06083690PFN: BGJ774HOUSING UNIT: 4B-3-34

1. CONTACT REQUEST: OUTSIDE AGENCY

☐DISTRICT
ATTORNEY☐PUBLIC
DEFENDER☐ADULT
PROBATION☐STATE
PAROLE☐OTHER
SPECIFY: _____

NATURE OF REQUEST: _____

2. CONTACT/INFORMATION: INSIDE FACILITY

CLASSIFICATION
SECTIONINMATE SERVICE
DIRECTORPROGRAMS
DIRECTORADMINISTRATIVE
BOOKING

OTHER

☐

REHOUSING

☐

COMMISSARY

☒ALEX
LAW
LIBRARY☐RELEASE
DATE☐

CHAPLAIN

☐

TRUSTEE

☐

MONEY ACCOUNT

☐

A.A.

☐

CHARGES

☐

FOOD SERVICE

☐

RECLASS.

☐

MAIL

☐FRIENDS
OUTSIDE☐

BAIL

☐

BAIL BONDS

☐

WWP

☐

LOST PROPERTY

☐OTHER:
SPECIFY
BELOW☐NEXT COURT
DATE☐OTHER:
SPECIFY BELOW☐

PSP

☐

LOST CLOTHING

NATURE OF REQUEST:

DUE TO MY DIFFICULTY IN ELICITING IMPORTANT
INFORMATION (PERTAINING TO THIS CASE) I HAVE
BEEN GIVEN AN ORDER FROM THE U.S. DISTRICT COURT GRANTING
EXTENSION OF TIME COULD YOU PLEASE COPY THIS ORDER
AND ALSO EXTEND MY PRO PER STATUS? THANK YOU!

3. ACTION TAKEN/RESPONSE

☒RESPONSE
BELOW☒REQUEST FORWARDED
OUTSIDE FACILITY☐REQUEST DENIED
SEE EXPLANATION☐CANNOT BE ACTED
ON AT THIS TIME.☐

PREVIOUS REQUEST IN PROGRESS

EXPLANATION/RESPONSE:

You will need to provide the DOC
proof of service by April 01, 2008. Your
status will continue.

OFFICER

SIGNATURE: REAGANBADGE # 2087 DATE 1-16-08 TIME 1725

SANTA CLARA COUNTY DEPARTMENT OF CORRECTIONS

FORWARD

RESEARCH

4B-3-46

I NEED TO FILE
SEPARATE "DIFFERENT" CIVIL COMPLAINTS.
THEREFORE I NEED SEPARATE CIVIL COMPLAINTS.
"YOU" SAID I HAVE A LIMIT OF 5 ITEMS, IF
THEY ARE ON SEPARATE LINE ITEM NUMBERS. THIS
IS A LIFE THREATENING COMPLAINT, CONSEQUENTLY

WHAT ACTION ARE YOU RECOMMENDING? 4 X 1983 COMPLAINTS RESPONSE FROM
DIRECTOR OF CORRECTIONS. I WILL WRITE A SECOND GRIEVANCE IN
OUR SIGNATURE: [Signature] Date: 8/7/07 Time: 4:30 PM
(Do not write below this line. Use additional sheets if necessary)

Received from inmate on:
Day: Tue Date: 08/07/07 Time: 2210 Officer: Richardson Team: C

RESPONDING OFFICER'S STATEMENT (Please print): Refer to legal counsel, Drury

☐ Resolved ☒ Refer to Level II
Supervisor's Name: [Signature] Team: C Date: 08/07/07

SUPERVISOR'S ACTION:

☐ Resolved ☐ Refer to Level III
Supervisor's Name: _____ Team: _____ Date: ____/____/____
SHERIFF-LIEUTENANT REVIEW: ☐ Concur ☐ Reversed

Date: ____/____/____ Time: ____:____:____
Service Response: Unit Assigned: _____ Date Assigned: ____/____/____

MAKE DATE 10 07 07 I AM SICK AND DO NOT HAVE THE TIME TO PLAY AROUND WITH CB.

Elmwood []
CCW []
WRC []

HOUSING UNIT: 4B 3 46

6885 REV 7/92

FEDERAL COURT ORDER NO. 007-9251 MHC (AR)

INMATE REQUEST FORM

U.S. DISTRICT JUDGE MAXINE M. CHESNEY

INMATE NAME: EDUARDO GUTIERREZ

DATE 12-13-07

CEN: 06083690

PIN: BEJ774

HOUSING UNIT: 4B-3-34

1. CONTACT REQUEST: OUTSIDE AGENCY

☐ DISTRICT ATTORNEY
 ☐ PUBLIC DEFENDER
 ☐ ADULT PROBATION
 ☐ STATE PAROLE
 ☐ OTHER SPECIFY: _____

NATURE OF REQUEST: _____

2. CONTACT/INFORMATION: INSIDE FACILITY

CLASSIFICATION SECTION	INMATE SERVICE DIRECTOR	PROGRAMS DIRECTOR	ADMINISTRATIVE BOOKING	OTHER
<input type="checkbox"/> REHOUSING	<input type="checkbox"/> COMMISSARY	<input type="checkbox"/> LAW LIBRARY	<input type="checkbox"/> RELEASE DATE	<input type="checkbox"/> CHAPLAIN
<input type="checkbox"/> TRUSTEE	<input type="checkbox"/> MONEY ACCOUNT	<input type="checkbox"/> A.A.	<input type="checkbox"/> CHARGES	<input type="checkbox"/> FOOD SERVICE
<input type="checkbox"/> RECLASS.	<input type="checkbox"/> MAIL	<input type="checkbox"/> FRIENDS OUTSIDE	<input type="checkbox"/> BAIL	<input type="checkbox"/> BAIL BONDS
<input type="checkbox"/> WWP	<input type="checkbox"/> LOST PROPERTY	<input checked="" type="checkbox"/> OTHER: SPECIFY BELOW	<input type="checkbox"/> NEXT COURT DATE	<input type="checkbox"/> OTHER: SPECIFY BELOW
<input type="checkbox"/> PSP	<input type="checkbox"/> LOST CLOTHING			

NATURE OF REQUEST: OFFICER OF 4B-3POD... COULD YOU PLEASE CALL LAW LIBRARY DIRECTOR AND INFORM HER THAT I HAVE AN ORDER GRANTING LEAVE TO PROCEED IN FORMA PAUPERIS WITH A 30 DAY DEADLINE TO RESPOND... I NEED PROPER STATUS TO PROPERLY RESPOND IN TIME.

3. ACTION TAKEN/RESPONSE

☐ RESPONSE BELOW
 ☐ REQUEST FORWARDED OUTSIDE FACILITY
 ☐ REQUEST DENIED SEE EXPLANATION
 ☐ CANNOT BE ACTED ON AT THIS TIME.

☐ PREVIOUS REQUEST IN PROGRESS

EXPLANATION/RESPONSE: _____

WARFIELD

BADGE 2612 DATE 12-14-07 TIME 0754

U.S. DISTRICT COURT CASE NO. 07-4251 MMC(PR)

INMATE REQUEST FORM

DIST. JUDGE MAXINE M. CHESNEY

INMATE NAME: EDWARD GUTIERREZ

DATE 12-14-07

CEN: 06083690

PFN: BGJ774

HOUSING UNIT: 4B-3-34

1. CONTACT REQUEST: OUTSIDE AGENCY

☐ DISTRICT ATTORNEY ☐ PUBLIC DEFENDER ☐ ADULT PROBATION ☐ STATE PAROLE ☐ OTHER SPECIFY: _____

NATURE OF REQUEST: _____

2. CONTACT/INFORMATION: INSIDE FACILITY

CLASSIFICATION SECTION	INMATE SERVICE DIRECTOR	PROGRAMS DIRECTOR	ADMINISTRATIVE BOOKING	OTHER
<input type="checkbox"/> REHOUSING	<input type="checkbox"/> COMMISSARY	<input type="checkbox"/> LAW LIBRARY	<input type="checkbox"/> RELEASE DATE	<input type="checkbox"/> CHAPLAIN
<input type="checkbox"/> TRUSTEE	<input type="checkbox"/> MONEY ACCOUNT	<input type="checkbox"/> A.A.	<input type="checkbox"/> CHARGES	<input type="checkbox"/> FOOD SERVICE
<input type="checkbox"/> RECLASS.	<input type="checkbox"/> MAIL	<input type="checkbox"/> FRIENDS OUTSIDE	<input type="checkbox"/> BAIL	<input type="checkbox"/> BAIL BONDS
<input type="checkbox"/> WWP	<input type="checkbox"/> LOST PROPERTY	<input type="checkbox"/> OTHER: SPECIFY BELOW	<input type="checkbox"/> NEXT COURT DATE	<input type="checkbox"/> OTHER: SPECIFY BELOW
<input type="checkbox"/> PSP	<input type="checkbox"/> LOST CLOTHING			

NATURE OF REQUEST: PLEASE CALL LAW LIBRARY DIRECTOR AND INFORM THIS DIRECTOR THAT I NEED PRO-PER STATUS FOR A FEDERAL CASE. CASE # NO. C07-4251 MMC(PR). I HAVE 25 DAYS TO RESPOND. I ASKED C/O WARFIELD TO CALL ON 12-14-07 BUT HE REFUSED.

3. ACTION TAKEN/RESPONSE

☒ RESPONSE BELOW ☐ REQUEST FORWARDED OUTSIDE FACILITY ☐ REQUEST DENIED SEE EXPLANATION ☐ CANNOT BE ACTED ON AT THIS TIME.

☐ PREVIOUS REQUEST IN PROGRESS

EXPLANATION/RESPONSE:

~~REFERRED TO ADMIN~~

See Inmate Request form from 12/17/07 NEVER RECEIVED 12-17-07 REQUEST FORMER RESPONSE.

OFFICER

SIGNATURE: Perez

BADGE #2736 DATE 12-17-2007 TIME 0810